

For use in the Stonewall Jackson Area Council ONLY

CUB SCOUT DAY CAMPS, CAMP SHENANDOAH FAMILY CAMP WEEKENDS, AND WEBELOS/CUB SCOUT RESIDENT CAMP

Scout Name _____

Class 1 Personal Health & Medical History

To be filled out **annually** by parent, guardian, or adult participant. Please print in ink.

Identification:

Name _____ Date of Birth _____ Age _____ Sex _____

Name of parent or guardian _____ Telephone _____

Home address _____ City _____ State _____ Zip _____

If person named above is not available in the event of an emergency, notify

Name _____ Relationship _____ Telephone _____

Name _____ Relationship _____ Telephone _____

Name of personal physician _____ Telephone _____

Personal health/accident insurance carrier _____ Policy No. _____

Check all that apply, past or present, to your health history. Explain any "Yes" answers.

Allergies: Food, medicines, insects, plants Yes No

Explain: _____

General Information:	Yes	No	Yes	No	Yes	No
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ADHD (Attention-Deficit)

Hyperactivity Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions/seizures	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
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Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
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Cancer/leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
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Explain: _____

Please list ALL medications taken in the 30 days prior to arrival at the Scouting activity where this form is to be used:

List any medications to be taken at camp: _____

List any physical or behavioral conditions that may affect or limit full participation in swimming, backpacking, hiking long distances, or playing strenuous physical games: _____

List equipment needed such as wheelchair, braces, glasses, contact lenses, etc.: _____

Immunizations: (Give date of last inoculation)

Tetanus	_____	Measles	_____	Polio	_____
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Diphtheria	_____	Mumps	_____
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Pertussis	_____	Rubella	_____
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I give permission for full participation in BSA programs, subject to limitations noted herein.

In case of emergency, I understand that every effort will be made to contact me (if participant is an adult, my spouse or next of kin). In the event I cannot be reached, I hereby give my permission to the licensed health-care practitioner selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child (or for me, if participant is an adult).

Date _____ Signature of parent/guardian _____

Pack # _____

Campsite _____