NAME

TROOP

CAMPSITE

PERSONAL HEALTH AND MEDICAL RECORD
CLASS 1

Class 1 (update annually for all participants). Activity: Day camp, overnight hike, or other programs not exceeding 72 hours, with level of activity similar to that of home or school. Medical care is readily available. Current personal health and medical summary (history) is attested by parents to be accurate.This form is filled out by all participants and is on file for easy reference.

CLASS 1 PERSONAL HEALTH AND MEDICAL HISTORY

(To be filled out annually by all participants)

To be filled out 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_____

Business 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 items 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
ADHD (Attention-Deficit Hyperactivity Disorder	☐	☐	Convulsions/seizures	☐	☐	Hemophilia	☐	☐
Asthma	☐	☐	Diabetes	☐	☐	High blood pressure	☐	☐
Cancer/leukemia	☐	☐	Heart trouble	☐	☐	Kidney disease	☐	☐

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 toxoid_____	Measles_____	Polio_____
Diphtheria _____	Mumps _____	_____
Pertussis _____	Rubella _____	_____

I give permission for full participation in BSA programs, subject to limitations noted herein.

In case of emergency, I understand 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 or adult_____

Some hospitals require the parent/guardian signature to be notarized.Check with your BSA local council.