

## PERSONAL HEALTH AND MEDICAL RECORD

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.

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| Name of parent or guardian   | Name   |                                      |  | Date of   | i birth    |                  | Age S             | ex      |       |  |
|--|--|--------------------------------------|--|-----------|------------|------------------|-------------------|---------|-------|--|
| 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 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 Yes No ADHD (Attention-Deficit Hyperactivity Disorder Diabetes High blood pressure Relations/Personal Heart trouble Ridney disease Diabetes  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 Polio  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 | Name of parent or guardian                               |                                      |  |           |            |                  | Telephone         |         |       |  |
| If person named above is not available in the event of an emergency, notify  Name Relationship Telephone  Name Relationship Telephone  Name Relationship Telephone  Name of personal physician Relationship 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 Yes No ADHI (Attention-Deficit Hyperactivity Disorder Diabetes High blood pressure Explain:  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 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.:  Inmunizations: (Give date of last inoculation.)  Tetanus toxoid Measles Polic  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  | Home address   | ressCity                             |  |           |            | State            | Zip               |         |       |  |
| Name Relationship Telephone Name Relationship Telephone Name Relationship Telephone Name of personal physician Relativaccident insurance carrier 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 Yes No ADHD (Attention-Deficit Hyperactivity Disorder Convulsions/seizures Hemophilia High blood pressure Explain:  Cancer/leukemia Diabetes High blood pressure Kidney disease Kidney disease 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 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.:  Inmunizations: (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  | Business address   | City                                 |  |           |            | State            | Zip               |         |       |  |
| Name   | If person named above is not                             | available in the $\epsilon$          | event of an emergency, not                                 | ify       |            |                  |                   |         |       |  |
| Name of personal physician   | Name   | Relationship                         |  |           | Telephone  |                  |                   |         |       |  |
| Personal health/accident insurance carrier   | Name   | Relationship                         |  |           |            | Telephone        |                   |         |       |  |
| 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 Yes No Yes No ADHD (Attention-Deficit Hyperactivity Disorder   | Name of personal physician_                              | Name of personal physician           |  |           | Telephone  |                  |                   |         |       |  |
| ALLERGIES: Food, medicines, insects, plants Yes No Yes No Yes No Yes No Yes No ADHD (Attention-Deficit Hyperactivity Disorder Convulsions/seizures Hemophilia High blood pressure Explain:    Cancer/leukemia Heart trouble Heart trouble Kidney disease   Explain:  | Personal health/accident insurance carrier               |                                      |  | Policy No |            |                  |                   |         |       |  |
| GENERAL INFORMATION: Yes No Yes No Yes No Yes No ADHD (Attention-Deficit Hyperactivity Disorder   Convulsions/seizures   Hemophilia   Sathma   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.)   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).  | Check all items that apply, pas                          | t or present, to                     | your health history.Explain                                | n any "   | Yes"answ   | ers.             |                   |         |       |  |
| ADHD (Attention-Deficit Hyperactivity Disorder   Convulsions/seizures   Hemophilia   Gasthma   Diabetes   High blood pressure   Explain:  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   | ALLERGIES: Food, medicines                               | s, insects, plants                   | Yes □ No □ Explai  | n:        |            |                  |                   |         |       |  |
| Hyperactivity Disorder   |  | Yes No                               |  | Yes       | No         |                  |                   | Yes     | No    |  |
| Cancer/leukemia  | •  |                                      |  |           |            |                  | •                 |         |       |  |
| Explain:  Please list ALL medications taken in the 30 days <b>prior</b> 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  |  |                                      |  |           |            | -                | · ·               |         |       |  |
| Please list ALL medications taken in the 30 days <b>prior</b> 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  |  |                                      |  |           |            | Marie            | y discase         |         | _     |  |
| or playing strenuous physical games:   |  |                                      |  |           |            |                  |                   |         |       |  |
| Immunizations: (Give date of last inoculation.)  Tetanus toxoid  |  |                                      | -  | -         |            | -                |                   | distar  | ices, |  |
| Tetanus toxoid   | List equipment needed such as                            | s wheelchair, bra                    | aces, glasses, contact lens                                | es, etc   | ).:        |                  |                   |         |       |  |
| 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   | Tetanus toxoid   |                                      | Measles<br>Mumps   |           |            |                  |                   |         |       |  |
| 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  | I give permission for full pa                            | rticipation in BS                    | A programs, subject to limi                                | tations   | s noted he | rein.            |                   |         |       |  |
|  | kin). In the event I cannot adult leader in charge to se | be reached, I he<br>ecure proper tre | ereby give my permission ta<br>atment, including hospitali | to the    | licensed h | nealth-care prac | ctitioner selecte | ed by t | he    |  |
|  | DateSign   | nature of parent                     | /guardian or adult   |           |            |                  |                   |         |       |  |
|  |  | •                                    | ~  |           |            |                  |                   |         | _     |  |