

DAY ACTIVITY HEALTH & MEDICAL RECORD

Greater Western Reserve Council, BSA



PERSONAL HEALTH AND MEDICAL HISTORY

(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
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>
Cancer/leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>
Convulsions/seizures	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>		<input type="checkbox"/>

Explain: _____

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 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 _____

CHILD RELEASE AUTHORIZATION (for participants under age 18)

Persons authorized to take youth from the event: _____ Phone Number: _____

Persons NOT authorized to take youth from the event: _____ Address/Phone Number: _____

In case of emergency, I understand every effort will be made to contact me (if an adult, spouse or next of kin). In the event I cannot be reached, I hereby give my permission to the physician 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 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.

Name _____ Unit (Circle One) Pack Troop Crew No. _____