For use in the Stonewall Jackson Area Council ONLY

*CUB SCOUT DAY CAMPS, CUB SCOUT AND WEBELOS RESIDENT CAMPS (**ALL UNDER 72 HOURS**)*

Scout Name ______________________ **Pack #** ______________________

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
ADHD	❒	❒	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 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 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 or adult______________________________