



# PERSONAL HEALTH AND MEDICAL RECORD

## CLASS 1

**Class 1 (update annually for all participants).** Activity: Day camp, overnight hike, or other program 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: \_\_\_\_\_

<b>GENERAL INFORMATION:</b>	Yes	No	Yes	No	Yes	No		
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"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<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, 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.**

NAME

UNIT

CABIN/DORM