National Capital Area Council, BSA | Cub Scout Day Camp

Unit Number
Date(s) Treated ___________

Personal Health and Medical Record
Class 1

Fill in this form for all day camp participants; including cub scouts, adults and siblings. This form will not be returned to you. Please make a copy and retain for your records.

To be completed annually by Parent/Guardian or Adult Participant. Please Print in Ink

Identification [ ] Scout [ ] Adult (18 & Older) [ ] Sibling

Name: ____Date of Birth _______________Age ____Sex_____

Name of Parent/Guardian: _______________________________________Home Phone: ____________________

Work Phone: ______________________ Cell Phone: ________________________

Home Address:_____________________________City:______________________State:______Zip:________

Email: ____

If person above is not available in the event of an emergency, notify:

Name:_______________________________Relationship:_______________Phone #:______________________

Name:_______________________________Relationship:_______________Phone #:______________________

Name of Personal Physician: ______________________________________Phone #:______________________

Personal Health/Accident Insurance Carrier:____

Policy Number: ____

Check all items that apply, past or present, to your health history. Explain any "Yes" answers.

ALLERGIES: Food, Medicines, Insects, Plants [ ] Yes [ ] No Explain: _____________________

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General Information:

	Yes	No		Yes	No		Yes	No
Asthma	[ ]	[ ]	Diabetes	[ ]	[ ]	High Blood Pressure	[ ]	[ ]
Attention Disorder Deficiency	[ ]	[ ]	Digestion	[ ]	[ ]	Kidney Disease	[ ]	[ ]
Cancer/Leukemia	[ ]	[ ]	Heart Trouble	[ ]	[ ]	Mental Illness	[ ]	[ ]
Convulsions/Seizures	[ ]	[ ]	Hemophillia	[ ]	[ ]	Lungs	[ ]	[ ]
Eyes, Ears, Nose, Throat	[ ]	[ ]				Takes Prescriptions Daily	[ ]	[ ]

Explain:____

List any medications to be taken at camp: ____

List any physical or behavioral conditions that may affect or limit full participation in any day camp activities:____

List equipment needed such as wheelchairs, braces, glasses, etc. ______________________________

ALL MEDICATIONS NEED TO BE CHECKED IN WITH THE CAMP MEDIC AND BE IN THE ORIGINAL PHARMACY CONTAINER WITH THE PATIENTS NAME AND DOSAGE CLEARLY MARKED. THIS INCLUDES ALL OVER THE COUNTER MEDICATIONS.

IMMUNIZATIONS: (Give Date of last inoculation)

Tetanus Toxoid: __________ Measles: __________ Polio: __________

Diphtheria:______________ Mumps:___________ Hepatitis B:____________

Pertussis:_______________ Rubella: __________

In case of emergency, I understand every effort will be made to contact me (if an adult, my 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: ____