

CUB SCOUT

CLASS 1 PERSONAL HEALTH AND MEDICAL HISTORY

(To be completed for ALL participants)

To be filled out by parent, guardian, or adult participant. Please print in blue or black ink. Use for all camps and activities under 72 hours.

IDENTIFICATION

Name _____ Date of Birth _____ Age _____ Sex _____

Name of parent/guardian, if under age 18 _____ Phone _____

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 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
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: _____

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 _____	_____
Pertussis _____	Rubella _____	_____

I give permission for full participation in all BSA Programs, subject to limitations noted herein.
 I give permission for photos, video and sound to be taken and published and distributed without limitation at the discretion of Greater Cleveland Council, BSA and I waive any right to any compensation for the foregoing.

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 _____