PERSONAL HEALTH AND MEDICAL RECORD

CLASS 1 AND CLASS 2

SAM HOUSTON AREA COUNCIL, B.S.A.

2004 - 2006

Class 1 (update annually for all participants). Activity: Day Camp, overnight hike, or other programs 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
(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, contact:

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

Name of personal physician_____Phone_____

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)	☐	☐	Convulsions/Seizures	☐	☐	Hemophillia	☐	☐
Asthma	☐	☐	Diabetes	☐	☐	High Blood Pressure	☐	☐
Cancer/leukemia	☐	☐	Heart Trouble	☐	☐	Kidney Disease	☐	☐

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 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 _____ Hepatitis B_____

Pertussis _____ Rubella _____ _____

I give permission for full participation in BSA program, subject to limitations noted herein.

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_____

Some hospitals require the parent/guardian signature to be notarized.

NAME_____ TROOP_____ CAMPSITE_____