

District \_\_\_\_\_ Event \_\_\_\_\_

## CLASS 1 PERSONAL HEALTH AND MEDICAL RECORD

**(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.

**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. \_\_\_\_\_

Authorization is granted for the release of the aforementioned individual to adult employees, staff, volunteers, and camp staff of The Tall Pine Council-Boy Scouts of America. In addition to the parent(s) or guardian(s) signing this form, only those individuals listed below are authorized to remove the aforementioned individual from camp during their period of camping.

**My Son or Daughter may leave this activity only with the following persons:**

1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_

### Please check medical information, past or present.

Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer/Leukemia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No	High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	ADHD	<input type="checkbox"/> Yes <input type="checkbox"/> No
Convulsions/Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other	<input type="checkbox"/> Yes <input type="checkbox"/> No

Explanations \_\_\_\_\_

Allergies: Food  Yes  No      Plants  Yes  No      Medicines  Yes  No      Insect bites  Yes  No

Explanations: \_\_\_\_\_

List any physical or behavioral conditions that may affect or limit full participation in swimming, long hikes, backpacking, or playing strenuous physical games: \_\_\_\_\_

List any medications to be taken at camp, including drug, dosage, route (oral, injection, etc.) and frequency: \_\_\_\_\_

List equipment needed such as wheelchair, braces, glasses, contacts, etc: \_\_\_\_\_

### IMMUNIZATION: Please provide immunization record – Copy of current immunization record may be attached

History of Shots Given by Series

Vaccine Series	Dose #1	Dose #2	Dose #3	Dose #4	Dose #5	Dose #6	Dose #7
DTP/DTaP/DT/Td/Tdap							
Polio							
MMR							
Hib							
Hepatitis B							
Varicella							
Hepatitis A							
Influenza							
Meningococcal Conjugate							

I hereby assign and grant to the Boy Scouts of America the right and permission to use and publish the photographs, film, videotapes, electronic representations and/or recordings made of my child or myself (if an adult) this date by the Boy Scouts of America, and I hereby release the Boy Scouts of America from any and all liabilities.

I hereby authorize the reproduction, sale, copyright, exhibit, broadcast, electronic storage and/or distribution of said photographs, film, videotapes, electronic representations and/or sound recordings without limitation at the discretion of the Boy Scouts of America and I specifically waive any right to compensation I may have for any of 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 \_\_\_\_\_ (Must be signed)

**Some hospitals require that the parent/guardian signature be notarized. Check with your BSA local council.**

NAME

UNIT

EVENT