



# Troop 323 - Boy Scouts of America

Chartered by All Saints Lutheran Church

Grand Canyon Council – Thunderbird District

## Personal Health and Medical Record Class 1

(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: \_\_\_\_\_ Phone: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

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

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of personal physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Personal health / accident insurance carrier: \_\_\_\_\_ Policy: \_\_\_\_\_

Allergies: Food, medicines, insects, plants Yes | No | Explain: \_\_\_\_\_

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

	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, or playing strenuous physical games or equipment needed such as wheelchair, braces, glasses, contact lenses, etc.: \_\_\_\_\_

### Immunizations: Give date of each

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 \_\_\_\_\_

This form must be notarized to be valid

Name: \_\_\_\_\_

Troop: \_\_\_\_\_

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