

**PERSONAL HEALTH AND MEDICAL RECORD  
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.** DISTRICT: \_\_\_\_\_ PACK # \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Name of parent or guardian \_\_\_\_\_ Telephone (H) \_\_\_\_\_ & (B) \_\_\_\_\_

Home address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Business address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ 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 you health history. Explain any "YES" answers.

ALLERGIES: Food, medicines, insects, plants: **Yes**  **No**  Explain: \_\_\_\_\_

**GENERAL INFORMATION:**

	<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>
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"/>
Convulsion/seizures	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<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: \_\_\_\_\_

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 \_\_\_\_\_

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 medications for my child (or for me, if an adult). Signature of parent/guardian or adult \_\_\_\_\_ Date: \_\_\_\_\_ Some hospitals require the parent/ guardian to be notarized. Check with your BSA local council.