



PERSONAL HEALTH AND MEDICAL RECORD

Class 1

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, 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		
Asthma	_____	_____	_____	Diabetes	_____	_____	High blood pressure	_____	_____
Cancer/leukemia	_____	_____	_____	Heart trouble	_____	_____	Kidney disease	_____	_____
Convulsions/seizures	_____	_____	_____	Hemophilia	_____	_____			

Explain: _____
 List any medications to be taken at camp: _____
 List any physical conditions that may affect or limit 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 _____	Rubelia _____	

I give full 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 permission to the physician selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia or injections of medications 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. Check with your BSA local council.