PERSONAL HEALTH AND MEDICAL RECORD

CLASS 1 AND CLASS 2

DIRECT SERVICE COUNCIL, B. S. A.

1999 - 2000

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, medicine, 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 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	_____
Diptheria	_____	Mumps	_____		_____
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 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