

**PERSONAL HEALTH AND  
MEDICAL RECORD  
CLASS 1**



**For: Cub Day Camp  
Cub Resident Camp  
Cub World**

Name \_\_\_\_\_

Pack # \_\_\_\_\_

**CLASS 1** (to be updated annually by all participants). Activity: Day camp, resident camp, Cub World programs, 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 (youths and adults) and is on file for easy reference. Please print in ink.

**IDENTIFICATION**

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

Name of parent or guardian \_\_\_\_\_ Phone # \_\_\_\_\_

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 \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

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

Personal health/accident insurance carrier \_\_\_\_\_ Policy No. \_\_\_\_\_

Check all items that apply, **past or present**, to health history of person named above. Explain any "yes" answers.

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

**GENERAL INVORMATION:**

ADHD (Attention-Deficit Hyperactivity Disorder)	Yes	No	Convulsions/Seizures	Yes	No	Hemophilia	Yes	No
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<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 all medications taken in the 30 days prior to arrival at the Scouting activity where this form is to be used:

\_\_\_\_\_

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 \_\_\_\_\_

OR DPT \_\_\_\_\_ OR MMR \_\_\_\_\_ Varicella \_\_\_\_\_

Hepatitis A \_\_\_\_\_ Hepatitis B \_\_\_\_\_ OR Chicken pox \_\_\_\_\_

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 participant is an adult, my spouse or next of kin). In the event I cannot be reached, I hereby give 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 \_\_\_\_\_

**Some hospitals require the parent/guardian signature be notarized.**