

HEALTH AND MEDICAL RECORD

Short Term Activities Only (Less than 5 days)

PLEASE FILL OUT THIS PAGE COMPLETELY

Name _____ Date of Birth _____ Unit _____
Address _____ Phone _____
City _____ State _____ Zip _____

IN CASE OF EMERGENCY NOTIFY:

Name _____ Relationship: Parent Guardian Other
Address _____ Phone (H) _____
(W) _____

My son may leave the activity only with the following adults _____

Health History

HAVE OR SUBJECT TO: (CHECK IF YES)

- asthma fainting spells
 diabetes heart trouble

Check here if none applies

- swimming or sports restrictions convulsions
 allergy/reaction to any medication other _____

HAVE DIFFICULTY WITH: (CHECK IF YES)

- eyes, ears, nose, throat digestion bed-wetting
 lungs sleepwalking

HAVE HAD: (CHECK IF YES)

- measles chickenpox German measles
 mumps whooping cough diphtheria

Any conditions now requiring medication? _____ Name of medication _____

Any restriction of activity for medical reasons? Explain: _____

IMMUNIZATIONS

Date of last inoculation

tetanus toxoid _____ measles _____ polio _____
German measles _____ mumps _____ diphtheria _____

The person named on this form is covered by the following medical insurance: _____

Group No. _____ Policy No. _____ Ident No. _____

Registration Information

PARENT'S AUTHORIZATION

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed activities, for the event indicated above, except as noted by me and the physician. In the event I cannot be reached in an emergency, I hereby give permission to the Physician selected by a designated representative of the Boy Scouts of America to authorize emergency medical or surgical treatment, routine, non-surgical medical care, hospitalize, secure proper anaesthesia, or to order injection(s) for my son/daughter. I agree to comply with the registration policies of the Gerald R. Ford Council - Boy Scouts of America.

ADULT'S AUTHORIZATION

In the event that I am injured and rendered unconscious, I hereby give permission to the Physician selected by a designated representative of the Boy Scouts of America to authorize emergency medical or surgical treatment, routine, non-surgical medical care, hospitalize, secure proper anaesthesia, or to order injection(s). I agree to comply with the registration policies of the Gerald R. Ford Council - Boy Scouts of America.

Signature of participant over 18 years of age.

Signature of Parent or guardian