

Name

NO SCOUT WILL BE PERMITTED TO REMAIN AT CAMP UNLESS A COPY OF THIS CLASS 1 FORM IS ON FILE IN THE HEALTH LODGE

CAMP CLASS 1 PERSONAL HEALTH AND MEDICAL HISTORY

Heart of America Council, Boy Scouts of America



Scout's Name _____ Social Security # _____ Date of Birth _____ Unit # _____

Name of parent or guardian _____ Telephone Number _____

Home Address _____ City _____ State _____ Zip _____

Cell Phone Number _____ Email Address _____

In the event the person named above cannot be reached in an emergency, please attempt to notify: Name _____ Relationship _____ Telephone # _____

Name of personal physician _____ Telephone # _____ Personal health/accident insurance carrier _____ Policy # _____

Allergies to medications (specify): _____ Describe the allergy _____

Allergies to any other substance (specify): _____ Describe the allergy _____

MEDICAL HISTORY (Check yes if past history or present problem)

ADHD	Yes	No	Heart Problem	Yes	No
Asthma	Yes	No	Bleeding Disorder	Yes	No
Cancer/Leukemia	Yes	No	High Blood Pressure	Yes	No
Convulsions/Seizures	Yes	No	Kidney Disease	Yes	No
Diabetes	Yes	No	Other: _____	Yes	No

Explanation of items checked "Yes"

Date of last Tetanus immunization or booster _____

List any other physical or behavioral condition that may affect or limit full participation in swimming, backpacking, hiking long distance, or playing strenuous games.

List any special equipment this Scout requires (wheelchair, brace, glasses, contact lenses, etc.)

YEAR 2007

COMPLETE THIS SECTION ONLY DURING THE YEAR 2007

MEDICATIONS TO BE TAKEN	DOSE	HOW OFTEN

Additional medical information

I give permission for full participation in BSA programs, subject to the limitations noted herein. In case of emergency, I understand that every effort will be made to contact me. In the event I cannot be reached, I hereby give permission to the licensed healthcare practitioner selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child.

I acknowledge the privacy policies of the Heart of America Council, BSA and understand that medical information related to illnesses or injuries sustained while participating in Scouting activities may be released to unit leaders, camp administration and health care insurance companies, on an as needed basis, to facilitate treatment or billing.

I hereby consent that the photographs for which he posed may be used by Heart of America Council, Boy Scouts of America, its assigns or successors, in whatever way they may desire, including television. Furthermore, I hereby consent that such photographs and the plates from which they are made shall be their property, and they shall have the right to sell, duplicate, reproduce in the form of advertising or otherwise publish and make other uses of such photographs and plates as they may desire – free and clear or any claim whatsoever on my part.

Parent or Guardian Signature _____ Date _____, 2007

Notes by Health Lodge Personnel

YEAR 2008

COMPLETE THIS SECTION ONLY DURING THE YEAR 2008

MEDICATIONS TO BE TAKEN	DOSE	HOW OFTEN

Changes in medical information since last summer, i.e. new problems, allergies, etc.

I give permission for full participation in BSA programs, subject to the limitations noted herein. In case of emergency, I understand that every effort will be made to contact me. In the event I cannot be reached, I hereby give permission to the licensed healthcare practitioner selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child.

I acknowledge the privacy policies of the Heart of America Council, BSA and understand that medical information related to illnesses or injuries sustained while participating in Scouting activities may be released to unit leaders, camp administration and health care insurance companies, on an as needed basis, to facilitate treatment or billing.

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Parent or Guardian Signature _____ Date _____, 2008

Notes by Health Lodge Personnel

YEAR 2009

COMPLETE THIS SECTION ONLY DURING THE YEAR 2009

MEDICATIONS TO BE TAKEN	DOSE	HOW OFTEN

Changes in medical information since last summer, i.e. new problems, allergies, etc.

I give permission for full participation in BSA programs, subject to the limitations noted herein. In case of emergency, I understand that every effort will be made to contact me. In the event I cannot be reached, I hereby give permission to the licensed healthcare practitioner selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child.

I acknowledge the privacy policies of the Heart of America Council, BSA and understand that medical information related to illnesses or injuries sustained while participating in Scouting activities may be released to unit leaders, camp administration and health care insurance companies, on an as needed basis, to facilitate treatment or billing.

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Parent or Guardian Signature _____ Date _____, 2009

Notes by Health Lodge Personnel

District

Unit #