



Class 1 Personal Health and Medical History
Troop 235 (BSA #34414)

Last Name _____

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.

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. _____

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 my 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).

Signature of parent/guardian or adult _____ **Date** _____

Some hospitals require the parent/guardian signature to be notarized. Check with you BSA local council.

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:

Asthma	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	High blood pressure	Yes <input type="checkbox"/>	No <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"/>
Convulsions/seizures	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>			

Explain: _____

List any medications to be take 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	____/____
Diphtheria	____/____	Mumps	____/____		____/____
Pertussis	____/____	Rubella	____/____		____/____

Optional non-emergency medical care: While away on an activity, I authorize a designated adult to administer the following medication(s) as necessary, according to label or special instructions. A Permission to Medicate form must be filled out for all prescription or regular/routine OTC medicines.

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Ibuprofen (Motrin/Advil) | <input type="checkbox"/> Acetaminophen (Tylenol) | <input type="checkbox"/> Throat Lozenges |
| <input type="checkbox"/> Decongestant (Sudafed) | <input type="checkbox"/> Antihistamine (ex: Benadryl) | <input type="checkbox"/> Cough Suppressant | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Pepto Bismal | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

Special instructions _____

Date _____ Signature of parent/guardian _____