



CLASS 1 PERSONAL HEALTH AND MEDICAL RECORD

Class 1 Activities: 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.

Please print in ink.

IDENTIFICATION

Name _____ Date of birth _____ Age _____ Gender _____

Name of parent, guardian, spouse _____ 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/Member No. _____

I give permission for full participation in BSA programs, 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 my 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 _____

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:	Yes	No		Yes	No		Yes	No
ADHD	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<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: _____

Please 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 _____*
Diphtheria _____*	Mumps _____*	_____
Pertussis _____*	Rubella _____*	_____

* Provide date if known; not required of adult participants