



HEALTH HISTORY
and
DAY CAMP ADULT & BOYSCOUT REGISTRATION



District _____ Pack/Troop # _____ Dates Attending _____ Camp Location _____

CLASS ONE ACTIVITY: Day camp, overnight hike, swimming party, 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 (or individual if adult) to be accurate. The form is filled out by all participants and is on file for easy reference.

IDENTIFICATION: (please print in ink or type clearly) Adult (>21yr) Den Chief (Scout 14-18)

Name _____ Pack # _____ Phone () _____

Address _____ Cell () _____

City _____ State _____ Zip _____ T-Shirt Size S M L XL 2XL 3XL

E-Mail _____ Sex _____ Age _____ Date of Birth _____

Which days will you attend? Monday Tuesday Wednesday Thursday Friday

Are you CPR certified? Yes No Are you 1st Aid certified? Yes No Are you BSA registered? Yes No

EMERGENCY INFORMATION:

Spouse/Next of kin _____ Phone # During hours of Day Camp _____

In the event of an emergency if person named above is not available notify:

Name _____ Relationship _____ Daytime Phone _____

Name of personal physician _____ Phone _____

Family health/accident insurance co. _____ Policy # _____

AN INSURANCE COMPANY & POLICY # MUST BE PROVIDED FOR ALL DAY CAMP PARTICIPANTS.

HEALTH HISTORY: (Check all items past or present that apply. Explain all "YES" answers.)

	Yes	No		Yes	No
ADD / ADHD	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Convulsion/seizure	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
Restriction of activities	<input type="checkbox"/>	<input type="checkbox"/>	Allergies (food, plants, insects,	<input type="checkbox"/>	<input type="checkbox"/>
for physical or behavioral reasons; other			medicine, bee stings, etc.)		

EXPLAIN: _____

IMMUNIZATIONS: (Give date of last inoculation or date of occurrence of disease.)

TDP _____ Polio _____ MMR _____

MEDICATIONS: (List those to be taken at camp.)

The medical information provided by me above is correct to the best of my knowledge. **In case of emergency**, I understand every effort will be made to contact spouse/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. **(The signature below must be dated within six months of attendance at camp.)**

Date _____ Signature _____

(If attendee is under 18, parent or guardian must sign.)

(Initial) _____ I further give do not give consent for photographs / videos depicting camp participant named above in day camp activities to be used by the Boy Scouts of America.

Name

Staff

Pack

Dates