



HEALTH HISTORY
and
YOUTH DAY CAMP REGISTRATION



District _____ Pack# _____ Dates Attending _____ Camp Location _____

Name _____
Pack _____
Dates _____

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)

Name _____ Pack # _____

Address _____ Telephone (____) _____

City _____ State _____ Zip _____ Sex _____ Age _____ Date of Birth _____

What grade will be completed in June this year? K 1st 2nd 3rd 4th 5th

Which program will you be in this summer? Tiger Cub Bear Wolf Webelos

Are you applying for a campership? yes no (If yes, please attached filled campership form)

T-Shirt Size: Youth / Adult (circle one) YS YM YL AS AM AL AXL

EMERGENCY INFORMATION:

Parent/Guardian _____ Email _____ Phone # During Day Camp _____

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

Name _____ Relationship _____ Daytime Phone _____

Name of personal physician _____ Phone _____

Family health/accident insurance co. _____ Policy # _____

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. The youth described herein has my permission to engage in all prescribed activities **except** as noted above by me. **In case of emergency**, I understand every effort will be made to contact me. 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. **(The signature below must be dated within six months of attendance at camp.)**

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

(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.

**CUB SCOUT DAY CAMP
RELEASE/PERMISSION TO PICK UP SLIP FOR:**

CUB SCOUT: _____

Is allowed to leave camp with:

_____ **ME**

_____ **Car pool adults as arranged by my pack (usually volunteer parents who are working at camp that day)**

_____ **The following people:**

	Name	Relationship	Phone Number
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

_____ **Will be transporting my son every day**

_____ **is NOT ALLOWED to take my child from camp**

Parent/Guardian Signature

Date