

PERSONAL HEALTH AND MEDICAL SUMMARY

UNIT # _____

To be completed by parent or guardian

NAME _____ Date of Birth _____ Age _____ Sex _____

NAME OF PARENT OR GUARDIAN _____ Telephone _____

HOME ADDRESS _____ City _____ State _____ Zip _____

BUSINESS NAME & ADDRESS _____ City _____

If the person above is not available in an emergency, please notify:

NAME _____ Relationship _____ Phone _____

NAME _____ Relationship _____ Phone _____

PERSONAL PHYSICIAN _____ **Telephone** _____

Medical information past or present: (Please check)

Asthma Yes _____ No _____ Heart Disease Yes _____ No _____ Leukemia Yes _____ No _____

Allergies Yes _____ No _____ High Blood Pressure Yes _____ No _____ Cancer Yes _____ No _____

ADD/ADHD Yes _____ No _____ Diabetes Yes _____ No _____ Hemophilia Yes _____ No _____

Seizures Yes _____ No _____ Other Yes _____ No _____

Explanations _____

Any special dietary instructions _____

Any reason to restrict full activity including swimming, long hikes, backpacking, strenuous physical games?

Yes _____ No _____

List any conditions limiting full participation _____

List any medications and directions for use _____

Any special orthopedic or handicap devices, glasses or contacts, dentures? Yes _____ No _____

What? _____

IMMUNIZATIONS: please give date of last inoculation. ("CURRENT" will not fulfill information for health officer.)

Tetanus Toxoid _____ Polio _____ Mumps _____

Diphtheria _____ Pertussus _____ Measles _____

Rubella _____ Hib _____ Chicken Pox _____

Hepatitis B _____

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, and/or injections of medications for my son.

Signed _____ **Date** _____

Each participant, scouts and adults, must complete a Health Form.

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