

Personal Health & Medical Record (Class 1)

DAY CAMP & AKELA CAMP USE ONLY

This form must be completed for each youth and adult participant in Day Camp or Akela Camp programs.
This form will not be returned, so please send a copy and retain the original for your records.

Name:	Date of Birth: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Home Address:	City:	State:	Zip:

Emergency Parent/Spouse/Family Member Contact:

Home Address:	City:	State:	Zip:
Work Address:	City:	State:	Zip:
Home Phone: ()	Work Phone: ()		extension:

***If the contact listed above is not available in the event of an emergency, please notify:
(For youth participants, please list at least one person besides a parent that can pick up your child)***

Name:	Relationship:	Phone: ()
Name:	Relationship:	Phone: ()
Name of Person Physician:		Phone: ()

Personal Health/Accident Insurance Carrier:	Policy #:
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*Check all items that apply. **past or present**, to your health history. Explain any "Yes" answers.*

ALLERGIES: Food, medication, insects, plants, etc. Yes No

Explain:

GENERAL INFORMATION:	<u>Yes</u>	<u>No</u>	<u>Yes</u>	<u>No</u>	<u>Yes</u>	<u>No</u>		
ADD/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"/>
<input type="checkbox"/> Other (please list):								

Explain any "Yes" answers from above:

Please list ALL medications taken in the 30 days **prior** to camp:

List ALL 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 dates of last inoculation or infection) UP-TO-DATE FOR AGE AS REQUIRED BY PUBLIC SCHOOL

Tetanus toxoid	Measles	Polio
Diphtheria	Mumps	Hep B
Pertussis	Rubella	Varicella (Chicken Pox Vaccine)

I give permission for full participation in BSA programs, subject to limitations noted above.

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).

Signature of Parent/Guardian or Adult:	Date: / /
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