PALMYRA DISTRICT BOY SCOUTS OF AMERICA
CLASS 1 PERSONAL HEALTH AND MEDICAL HISTORY
(Must be completed annually by all participants)

To be filled out by parent, guardian or adult participant. Please print in ink. **UNIT:**____________________

Name:____Date of Birth:_______________Age:____ Sex:________

Name of Parent or Guardian:____Telephone:________________

Home Address:________________________________City:________________State:________Zip:__________

Bus. 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 No.:________________

Check all items that apply: **past or present**, to your health history. Explain any "YES" answers.
Allergies: food, medicines, insects, plants, etc. ☐ Yes ☐ No Explain:__________________________________

____

General Information	Yes	No		Yes	No		Yes	No
Asthma	☐	☐	Diabetes	☐	☐	Hemophilia	☐	☐
Cancer / Leukemia	☐	☐	Hypoglycemia	☐	☐	High Blood Pressure	☐	☐
Convulsions/ Seizures	☐	☐	Heart Trouble	☐	☐	Kidney Disease	☐	☐

Explain:____

____

List any medications to be taken at camp:____

____

List any physical or behavioral conditions that may affect of limit full participation in swimming, backpacking, hiking long distances, or playing strenuous games:____

____

List equipment needed such as wheelchairs, braces, glasses, contact lenses, etc.,:_______________________

Immunizations: (give date of last inoculation)

	Date		Date		Date
Tetanus Toxoid		Measles		Polio	
Diphtheria		Mumps			
Pertussis		Rubella			

Publicity photographs and/or videotaping will occur during the course of the BSA activities. Please notify Unit Leadership with any concerns or special circumstances regarding photographs or videotaping.

I give my permission for full participation in BSA programs, subject to limitations noted herein. In the event of illness or accident in the course of such activity. I request that measures be instituted without delay as judgement of medical personnel dictates.

In case of emergency, I understand every effort will be made to contact me (If an adult, my spouse or 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 for my child (or for me, if an adult)

Date:_________________Signature of parent, guardian, or adult:____
Some hospitals require the parent/guardian signature to be notarized. Check with your BSA local council.