NO SCOUT WILL BE PERMITTED TO REMAIN AT CAMP UNLESS A COPY OF THIS CLASS 1 FORM IS ON FILE IN THE HEALTH LODGE

CAMP CLASS 1 PERSONAL HEALTH AND MEDICAL HISTORY

Heart of America Council, Boy Scouts of America

Scout's Name ________________________________Social Security #____________Date of Birth __________Unit #______

Name of parent or guardian ____Telephone Number ____________

Home Address ______________________________________City ____________________State ______Zip ______

Business Address ____________________________________City ____________________State ______Zip______

In the event the person named above cannot be reached in an emergency, please attempt to notify: Name ____________Relationship________Telephone # ________

Name of personal physician ______________Telephone # ________Personal health/accident insurance carrier ____________Policy #______

Allergies to medications (specify): ____________________________Describe the allergy ____________________________

Allergies to any other substance (specify): ________________________ Describe the allergy ____________________________

MEDICAL HISTORY (Check yes if past history or present problem)

ADHD	Yes	No	Heart Problem	Yes	No
Asthma	Yes	No	Bleeding Disorder	Yes	No
Cancer/Leukemia	Yes	No	High Blood Pressure	Yes	No
Convulsions/Seizures	Yes	No	Kidney Disease	Yes	No
Diabetes	Yes	No	Other:__________	Yes	No

Explanation of items checked "Yes"

Date of last Tetanus immunization or booster ________________

List any other physical or behavioral condition that may affect or limit full participation in swimming, backpacking, hiking long distance, or playing strenuous games.

List any special equipment this Scout requires (wheelchair, brace, glasses, contact lenses, etc.)

YEAR 2005

COMPLETE THIS SECTION ONLY DURING THE YEAR 2005

MEDICATIONS TO BE TAKEN	DOSE	HOW OFTEN

Additional medical information

Notes by Health Lodge Personnel

I give permission for full participation in BSA programs, subject to the limitations noted herein. In case of emergency, I understand that every effort will be made to contact me. In the event I cannot be reached, I hereby give permission to the licensed healthcare practitioner selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child.

I acknowledge the privacy policies of the Heart of America Council, BSA and understand that medical information related to illnesses or injuries sustained while participating in Scouting activities may be released to unit leaders, camp administration and health care insurance companies, on an as needed basis, to facilitate treatment or billing.

I hereby consent that the photographs for which he posed for or were taken candidly may be used by Heart of America Council, Boy Scouts of America, its assigns or successors, in whatever way they may desire, including television. Furthermore, I hereby consent that such photographs and the plates from which they are made shall be their property, and they shall have the right to sell, duplicate, reproduce in the form of advertising or otherwise publish and make other uses of such photographs and plates as they may desire – free and clear or any claim whatsoever on my part.

Parent or Guardian Signature ______________________________Date ______________, 2005

YEAR 2006

COMPLETE THIS SECTION ONLY DURING THE YEAR 2006

MEDICATIONS TO BE TAKEN	DOSE	HOW OFTEN

Changes in medical information since last summer, i.e. new problems, allergies, etc.

Notes by Health Lodge Personnel

I give permission for full participation in BSA programs, subject to the limitations noted herein. In case of emergency, I understand that every effort will be made to contact me. In the event I cannot be reached, I hereby give permission to the licensed healthcare practitioner selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child.

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Parent or Guardian Signature ______________________________Date ______________, 2006

YEAR 2007

COMPLETE THIS SECTION ONLY DURING THE YEAR 2007

MEDICATIONS TO BE TAKEN	DOSE	HOW OFTEN

Changes in medical information since last summer, i.e. new problems, allergies, etc.

Notes by Health Lodge Personnel

I give permission for full participation in BSA programs, subject to the limitations noted herein. In case of emergency, I understand that every effort will be made to contact me. In the event I cannot be reached, I hereby give permission to the licensed healthcare practitioner selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child.

I acknowledge the privacy policies of the Heart of America Council, BSA and understand that medical information related to illnesses or injuries sustained while participating in Scouting activities may be released to unit leaders, camp administration and health care insurance companies, on an as needed basis, to facilitate treatment or billing.

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Parent or Guardian Signature ______________________________Date ______________, 2007