

YOUTH CLASS | PERSONAL HEALTH HISTORY FORM

(Please print-make copies as needed) (Use this form for one youth only)

Pack _____ District _____

Cub Scout Name _____ Date of Birth _____ Age _____

Address _____ City _____ Zip _____

Name of personal physician _____ Telephone _____

Name of parent or guardian _____ Telephone _____

List allergies (foods, medicines, insects, plants, etc.) or mark none _____

Please list ALL medications taken in the 30 days prior to arrival at camp _____

GENERAL INFORMATION

- ADHD Convulsions/Seizures Hemophilia Asthma Diabetes
- High Blood Pressure Cancer/Leukemia Heart Trouble Kidney Disease

List any 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 date or mark up-to-date)

Tetanus _____ Pertussis _____ Mumps _____ Polio _____

Diphtheria _____ Measles _____ Rubella _____ Other _____

Personal health/accident insurance carrier _____ Policy # _____

Parent/guardian signature _____ Date _____

ADULT CLASS | PERSONAL HEALTH HISTORY FORM

(Please print-make copies as needed) (Use this form for one adult only)

Pack _____ District _____

Adult Name _____ Date of Birth _____ Age _____

Address _____ City _____ Zip _____

Name of personal physician _____ Telephone _____

List allergies (foods, medicines, insects, plants, etc.) or mark none _____

Please list ALL medications taken in the 30 days prior to arrival at camp _____

GENERAL INFORMATION

- ADHD Convulsions/Seizures Hemophilia Asthma Diabetes
- High Blood Pressure Cancer/Leukemia Heart Trouble Kidney Disease

List any 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 date or mark up-to-date)

Tetanus _____ Pertussis _____ Mumps _____ Polio _____

Diphtheria _____ Measles _____ Rubella _____ Other _____

Personal health/accident insurance carrier _____ Policy # _____

Signature _____ Date _____