

NAME: _____ UNIT: _____

Note: Keep original form for personal records. Make reproductions for agency use. Be sure information and signatures are legible on reproductions. The upper half of this form may be reproduced and carried for emergency identification purposes.

I. IDENTIFICATION: Age _____ Sex _____ Date of Birth _____

Name _____

Address _____

City&State _____ ZIP _____

Health / Accident Insurance _____

Policy # _____

IN AN EMERGENCY NOTIFY:

Name _____ Relationship _____

Daytime phone: _____ Evening phone: _____

Cellular phone: _____ Pager: _____

Personal Physician: _____ Phone: _____

INSTRUCTIONS

Physical examinations for campers must have been completed within the previous 24 months. Physical examinations for adults over 40 must have been completed within the previous 12 months. Parents must sign that the health history has been reviewed within the previous 12 months. Parents must complete all information on Page 1 of this form. Physician must complete all sections on Page 2, including the immunization record.

II. EMERGENCY MEDICAL INFORMATION:

Has or is subject to (check and give details):

Allergy to a medicine, plant, food, plant animal or insect toxin.

Any condition that may require special care, medication, or diet

ADHD (Attention Deficit Hyperactivity Disorder)

Asthma Convulsions Heart trouble Contact lenses

Diabetes Fainting spells Bleeding disorders Dentures

EXPLAIN: _____

III. MEDICATIONS TAKEN PRIOR TO CAMP

List all prescription medications administered within the 30 days prior to arrival at the Scouting activity for which this form is used:

IV. MEDICAL HISTORY

Parent (or applicant, if over 18): Fill in sections I, II, III and V before seeing physician. Check immunizations to be given at this time. Be sure to include any emergency information and restrictions or special care that should be observed. Especially be sure to record any injuries, illnesses, surgery, or significant changes in condition of health of applicant since last complete examination.

• Date of most recent complete physical examination (month and year): _____

• Are you aware of any current health problems? No Yes

• Now under medical care or taking medication? No Yes

• Has there been any surgery, injury, illness, allergy, or change in health since last complete examination? No Yes

• Has it been necessary to restrict applicant's activities for medical reasons? No Yes

If you answered "Yes" to any of the above, explain: _____

V. PARENTAL/APPLICANT STATEMENT

To the best of my knowledge, the information in sections I, II, III and IV is accurate and complete. I request licensed health-care practitioner to examine applicant, to give needed immunization, and to furnish required information to other agencies as needed. 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. I further authorize Yankee Clipper Council, BSA to use my or my son's likeness in print or electronic form for purposes consistent with the Aims of the Boy Scouts of America.

Parent or Guardian: **X** _____ (Must sign if applicant is under 18)

Applicant Signature: **X** _____

Date Signed: _____

Give dates and full details below for any "Yes" answers.

IS THERE PAST OR PRESENT HISTORY OF:

	No:	Yes:		No:	Yes:
Serious illness	<input type="checkbox"/>	<input type="checkbox"/>	Stomach, bowels	<input type="checkbox"/>	<input type="checkbox"/>
Serious injury	<input type="checkbox"/>	<input type="checkbox"/>	Appendicitis	<input type="checkbox"/>	<input type="checkbox"/>
Deformity	<input type="checkbox"/>	<input type="checkbox"/>	Kidneys or urine	<input type="checkbox"/>	<input type="checkbox"/>
Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Albumin	<input type="checkbox"/>	<input type="checkbox"/>
Skin, glands	<input type="checkbox"/>	<input type="checkbox"/>	Sugar	<input type="checkbox"/>	<input type="checkbox"/>
Ears, eyes	<input type="checkbox"/>	<input type="checkbox"/>	Infection	<input type="checkbox"/>	<input type="checkbox"/>
Nose, sinus	<input type="checkbox"/>	<input type="checkbox"/>	Bed Wetting	<input type="checkbox"/>	<input type="checkbox"/>
Teeth, tonsils	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual problems	<input type="checkbox"/>	<input type="checkbox"/>
Dentures	<input type="checkbox"/>	<input type="checkbox"/>	Hernia (rupture)	<input type="checkbox"/>	<input type="checkbox"/>
Bridge	<input type="checkbox"/>	<input type="checkbox"/>	Back, limbs, joints	<input type="checkbox"/>	<input type="checkbox"/>
Chest, lungs	<input type="checkbox"/>	<input type="checkbox"/>	Sleepwalking	<input type="checkbox"/>	<input type="checkbox"/>
Heart	<input type="checkbox"/>	<input type="checkbox"/>	Nervous condition	<input type="checkbox"/>	<input type="checkbox"/>
Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Other (explain)	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>			

If you answered "Yes" to any of the above, explain: _____

VI. PERMISSION TO ADMINISTER MEDICATIONS

I give the camp health officer, or BSA registered unit leader (for activities other than summer camp), or the designated health officer (for other activities) permission to administer the medications indicated by the licensed health-care practitioner on the reverse side and such over-the-counter medications, including but not be limited to Tylenol, Advil, or Benadryl as deemed necessary by the camp health officer, BSA registered unit leader (for activities other than summer camp), or the designated health officer (for other activities). Medications indicated under the allergies section of this form will not be administered.

Parent or Guardian: **X** _____ (Must sign if applicant is under 18)

Date Signed: _____

VII. PERMISSION TO LEAVE ACTIVITY

My son has my permission to leave this Scouting activity in the custody of persons listed here. My son will not be permitted to leave in the custody of any person not listed on this form with prior permission.

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

Parent or Guardian: **X** _____ (Must sign if applicant is under 18)

Date Signed: _____

LICENSED HEALTH-CARE PRACTITIONER MUST COMPLETE REVERSE SIDE

YCC Rev. 2007

