

# HEALTH HISTORY FOR CUB SCOUT CAMPERS & ADULTS

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Pack \_\_\_\_\_

Address \_\_\_\_\_

City or Town \_\_\_\_\_ State/Zip \_\_\_\_\_

## IN CASE OF EMERGENCY NOTIFY:

Name \_\_\_\_\_ Relationship:  Parent  Guardian  
 Other \_\_\_\_\_

Address \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_ Other Instructions \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

## HEALTH HISTORY

### Have or subject to: (check if yes)

- |  |  |
|--|--|
| <input type="checkbox"/> Asthma  | <input type="checkbox"/> Under care of physician<br>Describe _____ |
| <input type="checkbox"/> Fainting Spells   | <input type="checkbox"/> Recent serious injury<br>Describe _____   |
| <input type="checkbox"/> Convulsions   | <input type="checkbox"/> Other _____<br>Describe _____             |
| <input type="checkbox"/> Swimming or Sports restrictions   | <input type="checkbox"/> Special Needs<br>Describe _____           |
| <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Check Here if none of the above applies   |
| <input type="checkbox"/> Heart trouble   |  |
| <input type="checkbox"/> Allergies or reaction to any<br>medication, food or other<br>List _____ |  |

### Have difficulty with: (check if yes)

- Eyes     Ears     Nose     Throat     Lungs     Digestion
- Any condition now requiring regular medication? \_\_\_\_\_ Medication: \_\_\_\_\_
- Is his medication with him? If not, who has it? \_\_\_\_\_
- Any restriction of activity for medical reasons? \_\_\_\_\_ Explain: \_\_\_\_\_

**PARENT AUTHORIZATION:** *This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed activities, except as noted by me and the physician. In the event I cannot be reached in case of emergency, I hereby give permission to the physician, selected by the adult leader in charge, to hospitalize, secure proper anesthesia, or to order injection or surgery for my son.*

Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent or Guardian