



HEALTH HISTORY

BSA - CLASS 1
Valid For One year

Youth Member	<input type="checkbox"/>
Adult Under 40	<input type="checkbox"/>
Adult 40+	<input type="checkbox"/>

This form is used for

- ▶ annually updating the personal health and medical record
- ▶ and for programs not exceeding 72 hours where medical care is readily available.

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

IDENTIFICATION

Name _____ DOB ____/____/____ Age ____ Sex ____
 Name of parent or guardian _____ Telephone ____/____/____
 Home 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 insurance carrier _____ Policy No. _____

I give my permission for full participation in BSA programs, subject to limitations noted herein.

In case of emergency, I understand every effort will be made to contact me (if participant is an adult, my spouse or next of kin). In the event I cannot be reached, I hereby give my permission to the licensed health-care practitioner 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 participant is an adult).

Date ____/____/20____ Signature of parent/guardian or adult _____

Check all items that apply, past or present, to your health history. Explain any "Yes" answers.

ALLERGIES: Food, medicines, insects, plants Yes No Explain: _____

GENERAL INFORMATION:		Yes	No	Yes	No	Yes	No	
ADHD (Attention-Deficit Hyperactivity Disorder)	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions/seizures	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
						Surgery	<input type="checkbox"/>	<input type="checkbox"/>

Explain: _____

Please list ALL medications taken in the 30 days prior to arrival at the Scouting activity where this form is to be used: _____

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, glasses, contact lenses, etc: _____

Immunizations: (Give date most recent)

Tetanus _____	Measles _____	Polio _____
Diphtheria _____	Mumps _____	Hepatitis B _____
Pertussis _____	Rubella _____	

Name _____
Birthdate _____
Social Security # _____
Unit # _____