

FAMILY MEDICAL HISTORY FORM

FAMILY INFORMATION

Scout Name _____ Date of Birth _____ Den _____
Parents Names _____ Telephone _____
Home Address _____ City _____ State _____ Zip _____
Emergency Contact/Relationship _____ Phone _____
Medical insurance carrier _____ Policy No. _____

SCOUT INFORMATION

Check all items that apply, past or present, to the Scout's health history.

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Allergies (specify below)	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
ADHD (Attention Deficit Hyperactivity Disorder)	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
			Other	<input type="checkbox"/>	<input type="checkbox"/>

Explain any "Yes" answers: _____

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 any equipment needed, such as wheelchair, braces, glasses, contact lenses, etc.: _____

Immunizations (check if current):

Tetanus toxoid _____ Pertussis _____ Mumps _____ Polio _____
Diphtheria _____ Measles _____ Rubella _____

Name of Scout's physician _____ Telephone _____

Parent Authorization:

This health history is correct so far as I know, and the Scout has permission to engage in all prescribed activities, except as noted above. In the event of illness or accident in the course of any activity, I request that measures be instituted without delay as the judgment of medical personnel dictates.

Signature _____ Date _____

FATHER'S INFORMATION

Check all items that apply, past or present, to the Father's health history.

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Allergies (specify below)	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>

Explain any "Yes" answers: _____

List any other conditions that may be important in case of an emergency: _____

Name of personal physician _____ Telephone _____

MOTHER'S INFORMATION

Check all items that apply, past or present, to the Mother's health history.

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Allergies (specify below)	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>

Explain any "Yes" answers: _____

List any other conditions that may be important in case of an emergency: _____

Name of personal physician _____ Telephone _____