



GREATER PITTSBURGH COUNCIL

BOYS SCOUTS OF AMERICA

**DAY CAMP 2009 CUBS, ADULTS, STAFF AND PACK # \_\_\_\_\_**

**PERSONAL HEALTH AND MEDICAL RECORD - CLASS 1** Please print in ink.

This form is to be filled out annually by all participants and is kept on file for easy reference and is attested by parents to be accurate. This form must be completed in its entirety for the participant to attend Day Camp 2009

**IDENTIFICATION -CLASS 1 PERSONAL HEALTH AND MEDICAL HISTORY**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Name of Parent, Guardian or spouse \_\_\_\_\_ Phone \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

If person named above is not available in the event of an Emergency notify:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name of Personal Physician \_\_\_\_\_ Phone \_\_\_\_\_

Personal Health/Accident Insurance Carrier \_\_\_\_\_ Policy No. \_\_\_\_\_

**In case of Emergency** -I understand every effort will be made to contact me (my spouse or guardian). In the event I cannot be reached, I hereby give my permission to the licensed health-care practitioner to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child (or for me, if participant is an adult). **\*Signature of parent, guardian or adult** \_\_\_\_\_ **Date** \_\_\_\_\_

**MEDICAL INFORMATION PAST OR PRESENT (PLEASE CHECK)**

- |                     |            |                           |            |
|---------------------|------------|---------------------------|------------|
| ADHD                | __YES __NO | CONVULSIONS/SEIZURES      | __YES __NO |
| ASTHMA              | __YES __NO | DIABETES                  | __YES __NO |
| HEART DISEASE       | __YES __NO | HEMOPHILIA                | __YES __NO |
| ALLERGIES           | __YES __NO | KIDNEY DISEASE            | __YES __NO |
| HIGH BLOOD PRESSURE | __YES __NO | BEE STINGS/EPI PEN        | __YES __NO |
| CANCER/LEUKEMIA     | __YES __NO | <b>AUTISM / ASPERGERS</b> | __YES __NO |

**EXPLAINATIONS** \_\_\_\_\_

Is There Any Reason To Restrict Full Activity Including Swimming, Hikes or Games? \_\_\_\_YES \_\_\_\_NO

List Any Conditions Limiting Full Participation (Physical, Emotional or Behavioral) \_\_\_\_\_

Do You Have Medicines To Be Taken At Camp? \_\_\_\_Yes \_\_\_\_No

List Medicines, Send Ample Supplies And Directions For Use. (Asthma inhalers are to be carried on the person)

List Any Special Equipment Such As Orthopedic Or Handicap Devices, Glasses Or Contacts, Dentures?

Explain any yes answers and give all information needed to provide as safe and full participation as possible.

**IMMUNIZATIONS:** Date Of Last Inoculation - month/year (Do not attach your son's immunization records)

\***Tetanus** \_\_\_\_\_ Diphtheria \_\_\_\_\_ Polio \_\_\_\_\_ Pertussis \_\_\_\_\_ Measles \_\_\_\_\_ Mumps \_\_\_\_\_ Rubella \_\_\_\_\_

**PHOTO/VIDEO RELEASE**

I **consent** OR  I **do not consent** to the use of photographs/film/video/electronic representation or sound recordings made of my child or me during Day Camp and all liability from such use and publication.

**\*Signature** \_\_\_\_\_ (must be signed by parent or guardian if under 18)

NAME

PACK

DAY CAMP LOCATION