

**SEQUOIA COUNCIL, BOY SCOUTS OF AMERICA  
CUB SCOUT DAY CAMP  
HEALTH AND MEDICAL RECORD**

**This form to be  
turned in at  
camp**

**This form must be filled out for all participants  
TO BE FILLED OUT BY A PARENT OR GUARDIAN. PLEASE PRINT IN INK!!!**

**Child's/Adult's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Grade:** \_\_\_\_\_

**Name of Parent or Guardian:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Business or Emergency Phone:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_ **City, State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Business Address:** \_\_\_\_\_ **City, State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

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

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name of Personal Doctor: \_\_\_\_\_ Phone #: \_\_\_\_\_

Personal Health/Accident Insurance Carrier: \_\_\_\_\_ Policy #: \_\_\_\_\_

**IMPORTANT INFORMATION**

I give permission for full participation in the Cub Scout Day Camp program, subject to limitations noted herein. In case of an emergency, I understand that every effort will be made to contact me. In the event I cannot be reached, I hereby give my permission to the licensed health-care practitioner elected by the adult in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child.

I also give my permission for my child to participate in (please check):

\_\_\_\_\_ Archery \_\_\_\_\_ BB Gun Shooting \_\_\_\_\_ Horseback Riding

**I understand that blank boxes will prohibit my child from participating in these activities**

**I also give permission for photos of my son(s) to be used for publication**      Yes       No

**Date:** \_\_\_\_\_ **Signature of Parent/Guardian:** \_\_\_\_\_

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

**Allergies:** Food, Medicines, Insects, Plants: Yes  No  Explain: \_\_\_\_\_  
(Circle any that apply)

<b>General Information:</b>	<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>
ADHD	<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"/>

**Explain:**

\_\_\_\_\_

Please list ALL medications taken in the last 30 days prior to arrival at day camp: \_\_\_\_\_

List any medication to be taken during Day Camp: \_\_\_\_\_

List any physical or behavioral conditions that may affect or limit full participation in swimming, hiking, or playing strenuous physical games: \_\_\_\_\_

List equipment needed such as wheelchairs, braces, glasses, contact lenses, etc.: \_\_\_\_\_

**Immunizations: (Give date of last shots)**

Tetanus: \_\_\_\_\_

Measles: \_\_\_\_\_

Polio: \_\_\_\_\_

Diphtheria: \_\_\_\_\_

Mumps: \_\_\_\_\_

Pertussis: \_\_\_\_\_

Rubella: \_\_\_\_\_