This form to be turned in at camp

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

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

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)

General Information:	**Yes**	**No**		**Yes**	**No**		**Yes**	**No**
ADHD	☐	☐	Convulsions/Seizures	☐	☐	Hemophilia	☐	☐
Asthma	☐	☐	Diabetes	☐	☐	High Blood Pressure	☐	☐
Cancer/Leukemia	☐	☐	Heart Trouble	☐	☐	Kidney Disease	☐	☐

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: ___________________