



# Youth Health History – Cub Scout Day Camp Medical Form

(This form must be completed **entirely** and returned with the Registration.

This form will be on file at camp at all times – this is for your child's safety!)

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age (on 6/14/10): \_\_\_\_\_

## In Case of Emergency, notify: (must be able to pick up child if necessary)

If Parents/Guardians on page 1 can not be reached, in the event of an emergency notify:		
Name	Relation	Phone(s)
Health/Accident Insurance Co. and Policy #:		
Child's Primary Care Physician (Name and Number):		

## Problems with:

- Asthma       Fainting Spells       Convulsions       Diabetes       ADD / ADHD  
 Heart Trouble       Bleeding Disorders       Seizures       Digestion       Lungs  
 Eyes, ears, nose, throat       Allergy to medication, food, plant, insect, etc.       Other

Explain any checks above: \_\_\_\_\_

Any condition, disability, or allergy that may require special care, medication, or diet?

Explain: \_\_\_\_\_

**Note:** For the safety of the campers, any child that has disabilities and/or special needs **must have** a caregiver attend camp with them. If your son plans on attending camp and has disabilities and/or special needs, please contact the Day Camp Director prior to attending camp.

Any condition now requiring regular medication?     Yes     No

Name of medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Times to administer: \_\_\_\_\_

*All medication must be given to the first aid staff upon arrival at camp and must be in the original container! Please notify camp first aid staff if there are any health changes or anything else the staff should know about your child!*

Any restriction(s) of activities for medical reasons? (Explain) \_\_\_\_\_

My child may be administered Children's Tylenol by the first aid staff during camp:     Yes     No

**Immunization Information** – The Texas Dept. of Health requires **actual dates**. Registration will not be accepted unless the actual dates are listed. **Do not** put 'current', 'up to date', or 'on file with school or doctor'.

Immunization		Date of last inoculation	Immunization		Date of last inoculation	Immunization		Date of last inoculation
MMR	Measles		DPT	Diphtheria		Polio (OPV)		
	Mumps			Pertusis		Hepatitis B		
	Rubella			Tetanus toxoid		Varicella (Chicken Pox)		

## Consent to Treat:

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed activities, except as noted by me. In the event I or the persons designated above cannot be reached in an emergency, I hereby give permission to the physician selected by the adult leader in charge to hospitalize, secure proper anesthesia, or to order injection or surgery. I authorize the medical insurance carrier to make necessary payment directly to the physician or hospital for such treatment.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

