



**PERSONAL HEALTH AND MEDICAL HISTORY**  
**Required Annually for Scouts and Adults**

*To be filled out by parent, guardian, or adult participant. Required annually for all Troop 500 Registrants.*

**IDENTIFICATION** Scout \_\_\_\_\_ Adult \_\_\_\_\_ Date of This Form \_\_\_\_\_

Name \_\_\_\_\_ Date of birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Name of parent or guardian \_\_\_\_\_ Telephone \_\_\_\_\_

Home address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Telephone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Telephone \_\_\_\_\_

Name of personal physician \_\_\_\_\_ Telephone \_\_\_\_\_

Health/accident insurance carrier \_\_\_\_\_ Policy/patient No \_\_\_\_\_

**GENERAL INFORMATION.** Has this person ever had (check any that apply):

- |               |                |                      |                 |
|---------------|----------------|----------------------|-----------------|
| Asthma        | Diabetes       | High blood pressure  | Cancer/leukemia |
| Heart trouble | Kidney disease | Convulsions/seizures | Hemophilia      |

Does this person use an Inhaler? \_\_\_\_.

Is the person **allergic** to any food, insects, plants or medication? \_\_\_\_

**Explain** all yes answers above: \_\_\_\_\_

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 equipment needed such as wheelchair, contacts, etc.: \_\_\_\_\_

**IMMUNIZATIONS:** (give date of last inoculation or booster)

Tetanus toxoid \_\_\_\_\_ Measles \_\_\_\_\_ Polio \_\_\_\_\_

Diphtheria \_\_\_\_\_ Mumps \_\_\_\_\_ Others \_\_\_\_\_

Pertussis \_\_\_\_\_ Rubella \_\_\_\_\_

**In case of emergency,** I understand reasonable efforts will be made to contact me or the other parents or guardians of the child listed above (or if I am an adult, my spouse or next of kin). In the event I am not reached, I hereby consent to any emergency x-ray, anesthetic medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general of special supervision of any physician to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child (or for me, if an adult). This authorization is given in advance of any specific diagnosis, treatment, or hospital care being required. I additionally give authority to the adult leader in charge of any Boy Scouts of America activity to consent on my behalf (if me or the another parent, guardian, spouse or next of kin is not reached as described) to give specific consent to any and all such diagnosis, treatment or hospital care that such physician may deem advisable.

Signature of parent/guardian or adult \_\_\_\_\_ Date \_\_\_\_\_