

Camper Medical Form

Child's Name: _____ Date of birth: _____ Age: _____

Parent/Guardian:(please circle) _____

Home address: _____ City: _____ State: _____ Zip: _____

Home phone () _____ Work phone () _____ Cell () _____

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

Name: _____ Relationship: _____ Phone #: _____ Cell #: _____

Name: _____ Relationship: _____ Phone #: _____ Cell #: _____

Physician information:

Name of personal physician: _____ Telephone: _____

Personal health/accident insurance carrier _____

Policy No: _____ Telephone #: _____

Name of personal dentist: _____ Telephone: _____

Personal health/accident insurance carrier _____

Policy No: _____ Telephone #: _____

Physical description

Height: _____ Weight: _____ Hair: _____ Eyes: _____ Other description: _____

Medical History

Does the child have any of the following:

<input type="checkbox"/> Asthma	<input type="checkbox"/> Allergies – Medication	<input type="checkbox"/> ADD/ADHD
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Allergies – Food	<input type="checkbox"/> Current medication
<input type="checkbox"/> Fainting spells	<input type="checkbox"/> Allergies – Insects/Animals	<input type="checkbox"/> Heart trouble
<input type="checkbox"/> Sports restrictions	<input type="checkbox"/> Allergies – Plants	<input type="checkbox"/> Other (explain below)

Does the child have difficulty with any of the following:

Eyes Ears Other Throat Lungs

Please indicate all medications, allergies and restrictions: _____

Date of last Tetanus inoculation: _____

Parent or Guardian's Authorization

This health history is correct as far as I know, and the person herein described has permission to engage in all prescribed activities, except as noted by me. In case of emergency, I understand every effort will be made to contact me. In the event that I cannot be reached, I hereby give permission to the licensed health-care practitioner selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medications for my child.

Print Name: _____

Date: _____

Signature: _____

Relationship: _____

Photo Release

I understand that my son's picture may be taken during camp. I realize that that these photos may be used in future publicity for Cub Scouts Day Camp. I agree to the possibility that his picture may be used.

Print Name: _____

Date: _____

Signature: _____

Relationship: _____