

2006 Crater District Day Camp

PACK _____

NAME _____

Please indicate T-shirt size Youth M – L, Adult S – M – L – XL – XXL (Cub Scout – Webelos)

Cub Scout _____

Webelos _____

Class 1 Personal Health and Medical History

To be filled out by parent, guardian, or adult participant. **(Please print)**

NAME _____ DATE OF BIRTH _____ AGE _____ SEX _____

Name of parent or guardian _____ Telephone # _____

Home address _____ City _____

Telephone # (H) _____ (W) _____

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

NAME _____ Relationship _____ Telephone # _____

NAME _____ Relationship _____ Telephone # _____

Name of personal physician _____ Telephone # _____

Personal health /accident insurance carrier _____

In case of emergency, I understand every effort will be made to contact me(if an adult, my spouse or next of kin). In the event I cannot be reached, I hereby give my permission to the physician selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child (or for me, if an adult).

I give my permission for the Nurse to give Benedryl in case of Bee Sting. Signature _____

DATE _____ SIGNATURE OF PARENT / GUARDIAN OR ADULT _____

Check all items that apply, past or present, to your health history. Explain any "YES" answers.

ALLERGIES:

Food, medicines, insects, plants: Yes _____ No _____

Explain: _____

GENERAL INFORMATION: Yes No Yes No Yes No

Asthma _____ Diabetes _____ High blood pressure _____

Cancer/leukemia _____ Heart trouble _____ Convulsions/seizures _____

Bee sting* _____ Hemophilia _____ Kidney disease _____

*(Each boy must be able to administer his own medication)

Explain: _____

List any medications to be taken at camp: _____

(All medications must be turned in to camp nurse)

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

List equipment needed such as Wheelchair, braces, glasses, contact lenses, etc.: _____

IMMUNIZATIONS (give date of last inoculation)

Tetanus toxoid _____ Measles _____ Polio _____

Diphtheria _____ Mumps _____

Pertussis _____ Rubella _____