

# PERSONAL HEALTH HISTORY (CLASS 1)

**Class 1 (update annually for all participants).** Form required for the following activities: Overnight hike, resident camp; with level of activity similar to that of home or school. Medical care should be readily available. Current personal health and medical summary (history) is attested by parent/guardian or adult participant. This form must be filled out by all participants annually.

To be filled out by parent, guardian, or adult participant. **Please print in ink.**

**IDENTIFICATION**

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Home address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

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

Business address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Business Phone Number: \_\_\_\_\_ Personal Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_

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

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

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

Personal health/accident insurance carrier: \_\_\_\_\_ Policy No: \_\_\_\_\_

**GENERAL HEALTH** Check all items that apply, **past or present**, to your health history. Explain any "Yes" answers.

	Yes	No		Yes	No		Yes	No
Attention Deficit	___	___	Diabetes	___	___	Asthma	___	___
Cancer/Leukemia	___	___	Heart Trouble	___	___	Kidney Disease	___	___
Convulsions	___	___	Hemophilia	___	___	High blood pressure	___	___

Explain any above "yes" answers

- List any physical or behavioral conditions that may affect or limit full participation in swimming, backpacking, hiking long distances, or playing strenuously physical games
- List any equipment needed (wheelchair, braces, glasses, contacts, etc.)

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**LIST ALLERGIES:** (Plants, food, medicines, insects, other):

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**MEDICINES TO BE TAKEN AT CAMP AND DOSAGE:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**IMMUNIZATIONS:** Exact dates preferred, must be current on all.

Current (If dates are not available.)

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

Diphtheria \_\_\_\_\_ Mumps \_\_\_\_\_ Hep B \_\_\_\_\_

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

**TREATMENT AUTHORIZATION**  
**PARENT/GUARDIAN OF SCOUT OR ADULT PLEASE READ AND SIGN BELOW**  
 The information provided on this form is correct to the best of my knowledge. In the event of an emergency, if persons listed on the above as emergency contacts cannot be reached, I hereby give permission to the physician selected by the adult leader in charge to secure proper treatment, which may include anesthesia, surgery, or injections of medication.

**Date:** \_\_\_\_\_ **Signature of parent/guardian or adult participant:** \_\_\_\_\_

NAME \_\_\_\_\_ PACK 49 DEN \_\_\_\_\_ OHWAHINASEE DISTRICT Circle one: ADULT / SCOUT