# PERSONAL HEALTH AND MEDICAL RECORD

**CLASS 1 PERSONAL HEALTH AND MEDICAL HISTORY**
(To be filled out annually by all participants)

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

**IDENTIFICATION**

Name ______________________________________Date of Birth _________________Age ____________Sex _________

Name of Parent or Guardian _________________________________________________Telephone ___________________

Home Address _______________________________City ________________________State ______ Zip ______________

Business Telephone(s): Dad __________________________________ Mother ___________________________________

If person(s) named above are 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 ________________________________________Policy No.__________________

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 |
|---|---|---|---|---|---|---|---|---|
| ADHD (Attention-Deficit/ Hyperactivity Disorder | ☐ | ☐ | Convulsions/seizures | ☐ | ☐ | Hemophilia | ☐ | ☐ |
| Asthma | ☐ | ☐ | Diabetes | ☐ | ☐ | High blood pressure | ☐ | ☐ |
| Cancer/leukemia | ☐ | ☐ | Heart trouble | ☐ | ☐ | Kidney disease | ☐ | ☐ |

Explain: ______________________________________________________________________________________

Please list ALL medications taken in the 30 days **prior** to arrival at the Scouting activity where this form is to be used: _____

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List any medications to be taken at camp/event:_______________________________________________________________

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, braces, glasses, contact lenses, etc:_______________________________________

Immunizations: (Give date of last inoculation.)

| | | | | | |
|---|---|---|---|---|---|
| Tetanus toxoid | ________________________ | Measles | ____________________ | Polio | ______________________ |
| Diphtheria | ________________________ | Mumps | ____________________ | Chicken Pox | ________________ |
| Pertussis | ________________________ | Rubella | ____________________ | | ___________________________ |

**I give permission for full participation in BSA programs, subject to limitations noted herein.**

For value received, I hereby consent to the use of my (or my daughter’s or son’s if participant is under 18) name, voice and /or pictures by the Boy Scouts of America, and/or any movie, news, or broadcasting companies or their licensees for broadcasting, direct exhibition, publication and subsidiary purposes. Such uses will not be made which would constitute a direct endorsement by said participant or adult of any product or service.

We agree to all terms and conditions of the Waiver of Claims as stated on the back of this form

**In case of emergency,** I understand every effort will be made to contact me (if participant is an adult, my spouse or next of kin). In the event I cannot be reached, I hereby give my 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 medication for my child (or for me, if participant is an adult).

Date ____________________ Signature of parent/guardian or adult _____________________________________________

Name ______________________ Group/Unit ______________________ Housing ______________________

## WAIVER OF CLAIMS

In consideration of the benefits to be derived from participation in this trip or activity, any and all claims against the Boy Scouts of America, Pack, Troop , Team, Crew, Council, Lodge, and Chartered Organization, or against the officers, employees, agents, or other representatives of any of them, or any other persons working under their direction or engaged in the conduct of their affairs, arising out of any accident, illness, injury, damage or other loss or harm to/or incurred or suffered by the applicant named on the front side of this "Personal Health & Medical Record" or to his or her property, in connection with or incidental to the trip or activity, including preliminary training and travel, are hereby expressly waived by the applicant and/or the applicants parent(s) or guardian(s).

## ACCIDENT & SICKNESS INSURANCE

We acknowledge that Accident and Sickness Insurance has been obtained for this trip which coordinates with any family health and medical insurance. Any and all incidences which may require coverage by this insurance should be reported as soon as possible to the Staff Adviser at the event.

**Claim Forms may be attained from the Program Office of the**

**Daniel Webster Council, 571 Holt Avenue, Manchester, NH 03109**

**attn: Craig McPherson, 603-625-6431**

## USE OF OTHER BSA FORMS AND NON RETURN NOTICES

This "Personal Health & Medical Record" will not be returned to the participant at the conclusion of the event. Any approved and signed BSA Class 1, Class 2, Class 3, Philmont or Jamboree Health and/or Medical form may also be submitted in addition to or in lieu of this form except that the consent for media use, and Waiver of Claims statement on the front of this form must be signed and dated. Only copies of the other forms should be used since these records will not be returned after the event.