

# PERSONAL HEALTH AND MEDICAL SUMMARY

To be filled out by parent or guardian, as required.

## IDENTIFICATION

District \_\_\_\_\_ Unit # \_\_\_\_\_

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

If minor, name of parent or guardian \_\_\_\_\_ Telephone \_\_\_\_\_

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

Business address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

IF THE 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 \_\_\_\_\_ Policy No. \_\_\_\_\_

## Medical information, past or present (please check all; explain all "yes" answers below)

Asthma Yes  No  Heart Disease Yes  No  Leukemia Yes  No

ADHD Yes  No  High Blood Pressure Yes  No  Cancer Yes  No

Convulsions Yes  No  Diabetes Yes  No  Hemophilia Yes  No

Explanations \_\_\_\_\_

Allergies: Food Yes  No  Plants Yes  No

Medicines Yes  No  Insect Bites Yes  No

Explanations: \_\_\_\_\_

Any reason to restrict full activity including swimming, long hikes, strenuous physical games? Yes  No

List any conditions limiting full participation (Physical or Emotional) \_\_\_\_\_

Any reason for medicines to be taken at camp? Yes  No  If child is ADHD please continue treatment while at camp.

List medicines, send ample supplies and directions for use. \_\_\_\_\_

Any special equipment such as orthopedic or handicap devices, glasses or contacts, dentures? Yes  No

What? \_\_\_\_\_

## Immunizations:

Date of last  
inoculation

Date of last  
inoculation

Date of last  
inoculation

Tetanus Toxoid \_\_\_\_\_ Polio \_\_\_\_\_

Mumps \_\_\_\_\_

Diphtheria \_\_\_\_\_ Pertussis \_\_\_\_\_

Measles \_\_\_\_\_

Rubella \_\_\_\_\_

**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 my permission to the physician selected by the adult leader in charge to secure proper treatment which may include hospitalization, anesthesia, surgery, or injections of medication for my son.

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