Del-Mar-Va Council, Inc., BSA
Cub Scout Day Camp

Pack #

HEALTH INFORMATION FOR CUB SCOUTS

CUB SCOUT INFORMATION

Name ____ **Date of Birth** _____-_____-_____

Height __________ Weight __________ Eye Color __________ Hair Color __________

Address ____

City ______________________________ State _________ Zip _____________ Home Phone __________________

Grade this coming September _______________________

PARENT/GUARDIAN/SPOUSE INFORMATION

Name ________________________ Relation to Scout ______________ Day Phone __________ Cell/Pager __________

Name ________________________ Relation to Scout ______________ Day Phone __________ Cell/Pager __________

EMERGENCY CONTACTS (other than parent/guardian/spouse)

Name ________________________ Relation to Scout ______________ Day Phone __________ Cell/Pager __________

Name ________________________ Relation to Scout ______________ Day Phone __________ Cell/Pager __________

HEALTH HISTORY: Check all items that apply, past or present, to this 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	___	___	Kidney Disease	___	___
Convulsions	___	___	Seizures	___	___	Hemophilia	___	___

List any medications now being taken: ____

List any medications to be taken while at camp: ____

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, contacts etc.: _______________________________

IMMUNIZATIONS: ***MUST give month and year of last inoculation. This section must be completed or participation will be denied.***

Tetanus Toxoid	__________	Pertussis	__________	Mumps	__________	Rubella	__________
Diphtheria	__________	Measles	__________	Polio	__________	TB Tine	__________
Chicken Pox	__________	Hepatitis B	__________				

PERSONAL (FAMILY) PHYSICIAN ______________________________ Phone ________________________________

Personal health/accident insurance carrier ____

Policy # _____________________________________ Policy Holder _____________________________________

PARENT 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 the event I cannot be reached in an emergency, I hereby give permission to the physician. Selected by the adult leader in charge, to hospitalize, secure proper anesthesia, or to order injection or surgery for my son.

I also consent to the use of photographs, videotape, voice recordings and written extractions, in whole or part, of the above named individual for the purpose of illustrations, promotion or publications. (Cross out and initial if you do not consent).

SIGNATURE ________________________________ PRINTED __________________________ DATE ___________