Troop #460 Health History and Emergency Information

Please attach a recent (dated) photograph of your scout to this form

Name _____ Birth date _____

Address _____ Phone (_____)_____
number street city state zip

Parents/Guardians:

(1) Name _____ Home Phone (_____) _____

Place of work _____ Title _____ Work Phone (_____)_____

(2) Name _____ Home Phone (_____) _____

Place of work _____ Title _____ Work Phone (_____)_____

If parents can't be reached, call (Name) _____ Phone (_____)_____

Address _____ Relationship _____

Health Insurance Company _____ Policy Number_____

Name of Family Physician _____ Phone (_____)_____

Name of Dentist/Orthodontist _____ Phone (_____)_____

HEALTH HISTORY: (Write **Yes** or **No**)

Ear infections	____	Behavior problems	____	Special shoes	____	Asthma	____
Nose bleeds	____	Bleeding/clotting disorders	____	Chicken Pox	____	Poison Oak	____
Heart disease	____	Lyme Disease	____	Measles	____	Insect Stings	____
Diabetes	____	Hearing Aid	____	Rubella	____	Food	____
Seizures	____	Glasses	____	Mumps	____	Drugs	____
Fainting	____	Contact Lenses	____	**Allergies:**		Other	____
Bed-wetting	____	Dental braces	____	Hayfever	____		
Sleep walking	____	Orthopedic braces	____	Animals	____	Special diet	____

Details of any **Yes** above (especially allergic reactions to bee stings or food and how do you handle it at home?)

_____

Is the child currently under the care of a physician or psychologist? _____ Yes _____ No Details_____

_____

Any activity restrictions? _____

_____

List any medications being taken by scout. Prescription medication must be in original bottle and labeled with the scouts name, address and instructions.

MEDICATION DOSAGE PURPOSE

_____

_____

Immunization History	Year Primary Series Completed	Year of Last Booster	Immunization History	Year Primary Series Completed	Year of Last Booster
Diphtheria	_____	_____	Measles	_____	_____
Tetanus	_____	_____	Mumps	_____	_____
Whooping Cough	_____	_____	Rubella	_____	_____
Oral Polio	_____	_____	Other	_____	_____

This health history is true and correct to the best of my knowledge and the person herein described has my permission to engage in all prescribed activities except as noted by me. In the event that I cannot be reached in an emergency, I hereby give permission in advance of need to the physician selected by the adult leader in charge for diagnosis, treatment or hospital care.

Date _____ Signature of parent or legal guardian _____