

CUB SCOUT YOUTH HEALTH & MEDICAL RECORD

Parent/Guardian:
CUB SCOUT RESIDENT CAMPERS requires only the completion of the HEALTH HISTORY within the last 12 months.

Name of Youth Last Name First Name Initial Date of Birth Age

Youth Home Address City State

Medical Provider (Youth) Provider Phone ( )

Family Health/Accident Insurance Policy No.

IN CASE OF EMERGENCY, NOTIFY:

Name of parent/Guardian AM Phone ( )

Home Address PM Phone ( )

City State Zip Pager

Alternate Phone ( ) Relationship

Alternate Phone ( ) Relationship

YOUTH HEALTH HISTORY (To completed by Custodial Parent/Guardian)

IF YES IS CHECKED, PLEASE GIVE FULL DETAILS

\*HAVE OR SUBJECT TO: (Check if YES) IF NONE: Check here
Heart Problems Asthma \*\*\*\*\* Uses an Inhaler No Yes
Seizure Disorder Diabetes \*\*\*\*\* Uses Insulin No Yes
Kidney Disorder Behavioral/Emotional Concerns
Medication Allergies: List
Food Allergies: List
Seasonal Allergies: List
Stinging Insect Reaction: Treatment
Other health Concern(s)

\*HAVE DIFFICULTY WITH: (Check if YES) IF NONE: Check here
Tires easily Muscle Fatigue Ear Infections
Breathing Nose Bleeding Sinus Infections
Stomach/Bowels Sleeping Athletes Foot
Explain:

\*CURRENT HEALTH STATUS: (Check if YES) IF NONE: Check here
Currently under medical care. Explain:
Currently taking any medications. Complete CURRENT MEDICATION SECTION
Serious illness/injury in past year. Explain:
Current ear, nose or throat infection. Explain:
Current cold or seasonal allergy. Explain:
Current behavioral/emotional concerns. Explain:
Dental Concerns Explain:
Diet restrictions. Explain:
Activity restrictions. Explain:
Wears contacts
Other current health concerns. Explain:

THE FOLLOWING IMMUNIZATIONS ARE CURRENT AND UP TO DATE:

(MUST indicate last inoculation dates(s))

MMR (measles, mumps, rubella), DPT (diphtheria, pertussis, tetanus),
Polio, Smallpox, Varicella (Chicken Pox) other
Tetanus Booster

Campsite

Team #

Crew #

Troop #

Pack #

Name

**CURRENT MEDICATIONS: (Prescription & Non-Prescription)**

\_\_\_\_\_ My son (daughter) takes **NO** medications on a routine basis.

My son (daughter) takes the following medications on a regular basis.

Med #1 \_\_\_\_\_ Dosage \_\_\_\_\_ Times to be given \_\_\_\_\_

Reason for taking above medication: \_\_\_\_\_

Med #2 \_\_\_\_\_ Dosage \_\_\_\_\_ Times to be given \_\_\_\_\_

Reason for taking above medication: \_\_\_\_\_

Med #3 \_\_\_\_\_ Dosage \_\_\_\_\_ Times to be given \_\_\_\_\_

Reason for taking above medication: \_\_\_\_\_

Attach additional pages for more medications.

I (we) give permission for my (our) son to receive the following over the counter medications as determined necessary by an authorized BSA employee, camp staff or volunteer for purposes of First Aid and Safety:

\_\_\_\_\_ **NONE**      \_\_\_\_\_ Pain/Fever relievers      \_\_\_\_\_ Antihistamines      \_\_\_\_\_ Anti-diarrheas  
\_\_\_\_\_ Anti-acids      \_\_\_\_\_ Cough/Cold meds      \_\_\_\_\_ Topical Antibiotics & Anti-itch Ointments  
\_\_\_\_\_ Other \_\_\_\_\_

➤ Custodial parent/Guardian Signature: \_\_\_\_\_ Date \_\_\_\_\_

**STATE OF MICHIGAN REQUIRED AUTHORIZATIONS**

*The Michigan Department of Consumer and Industry Services pursuant to Public Act 116 of 1973 and administrative Rule 127.1(1) **REQUIRES the following authorization:***

- The person herein described is in GOOD HEALTH and has all required immunizations. The information and health history contained herein is accurate and complete. Permission is granted for full participation in BSA programs and activities, subject to limitations noted herein. In the event I (we) cannot be reached in emergency, I (we) hereby grant permission to the medical provider selected by BSA representatives to authorize emergency medical/surgical treatment, routine non-surgical medical care, hospitalization, proper anesthesia and/or medications(s)/injections(s) for my (our) son (daughter). I (we) assume health & financial responsibility for the aforementioned individual.

\_\_\_\_\_

Date	Parent/Guardian Signature	Print Name
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*The Michigan Department of Consumer and Industry Service pursuant to Public Act 116 of 1973 and Administrative Rule 117.(2)(a) **REQUIRES the following information.***

- Authorization is granted for the release of the aforementioned individual to adult employees, camp staff, and volunteers of the Southwest Michigan Council, Boy Scouts of America. In addition, to the parents and guardians signing this form, only those individuals listed below are authorized to remove the aforementioned individual from summer camp during their period of camping.

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_