

YOUTH HEALTH FORM – ALL CUB SCOUT SUMMER CAMPS

PLEASE PRINT CLEARLY IN COMPLETING THIS FORM

Name of Scout \_\_\_\_\_ Date of Birth \_\_\_\_\_

Name of Parent(s) \_\_\_\_\_

Address \_\_\_\_\_ City/Zip \_\_\_\_\_

Health/Accident Insurance Co \_\_\_\_\_ Group & Policy # \_\_\_\_\_

HEALTH CONCERNS: Do you have or are you subject to: (Check if Yes)

Asthma  Fainting Spells  Heart Trouble  Convulsions  Diabetes  Bleeding Disorders

Allergy to any medication, food, plant, animal or insect toxin (Describe be specific): \_\_\_\_\_

Any Condition that may require special care, medication, or diet (Describe be specific): \_\_\_\_\_

None of the above applies

Have difficulty with:  Eyes, ears, nose, throat  Digestion  Sleepwalking  Breathing

(Check if YES)  Other (Explain) \_\_\_\_\_

Any condition requiring regular medication? Explain \_\_\_\_\_

Any restriction of activity for medical reasons? Explain \_\_\_\_\_

IMMUNIZATION: Give date of last inoculation for each of these:

Tetanus \_\_\_\_\_ Diphtheria \_\_\_\_\_ Polio \_\_\_\_\_ Measles/Mumps/Rubella \_\_\_\_\_

CARE AUTHORIZATION: This health history is correct as I know, and the person herein described has permission to engage in all prescribed activities, except as noted. 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.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Home Telephone \_\_\_\_\_ Business Telephone Number \_\_\_\_\_

Alternate Emergency Contact & Relationship \_\_\_\_\_ Phone Number \_\_\_\_\_

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ADULT HEALTH FORM – ALL CUB SCOUT SUMMER CAMPS  
PLEASE PRINT CLEARLY IN COMPLETING THIS FORM

Name of Adult \_\_\_\_\_ Date of Birth \_\_\_\_\_

Emergency Contact \_\_\_\_\_

Address \_\_\_\_\_ City/Zip \_\_\_\_\_

Health/Accident Insurance Co \_\_\_\_\_ Group & Policy # \_\_\_\_\_

HEALTH CONCERNS: Do you have or are you subject to: (Check if Yes)

Asthma  Fainting Spells  Heart Trouble  Convulsions  Diabetes  Bleeding Disorders

Allergy to any medication, food, plant, animal or insect toxin (Describe be specific): \_\_\_\_\_

Any Condition that may require special care, medication, or diet (Describe be specific): \_\_\_\_\_

None of the above applies

Have difficulty with:  Eyes, ears, nose, throat  Digestion  Sleepwalking  Breathing

(Check if YES)  Other (Explain) \_\_\_\_\_

Any condition requiring regular medication? Explain \_\_\_\_\_

Any restriction of activity for medical reasons? Explain \_\_\_\_\_

IMMUNIZATION: Give date of last inoculation for each of these:

Tetanus \_\_\_\_\_ Diphtheria \_\_\_\_\_ Polio \_\_\_\_\_ Measles/Mumps/Rubella \_\_\_\_\_

CARE AUTHORIZATION: This health history is correct as I know, and the person herein described has permission to engage in all prescribed activities, except as noted. 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.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Home Telephone \_\_\_\_\_ Business Telephone Number \_\_\_\_\_

Alternate Emergency Contact & Relationship \_\_\_\_\_ Phone Number \_\_\_\_\_