



Colorado Boy Scout Camps Health & Medical Record

This form is valid for 12 months.

Personal Health and Medical Record—Class 1 and 3

Instructions: By completing sections 1, 2, and 3, this form qualifies as a Class 1 medical history. By completing all sections (page 1 and 2); this form qualifies as a Class 2 or 3 medical record.

Who needs a Class 1? Anyone attending Cub Scout Day Camps and any overnight activities less than 72 hours.

Who needs a Class 3? Anyone attending a high Adventure Base or Boy Scout Camp (longer than 72 hours).

NOTE: ALL MEDICATIONS MUST BE IN ORIGINAL CONTAINER WITH PHARMACY LABEL!

LAST NAME

FIRST INITIAL

ALLERGIES

UNIT # _____
SESSION # _____

1. Personal and Emergency Contact Information

Name: _____ Date of Birth: _____ Age: _____ Sex: _____

Address: _____ City, State, Zip _____ Phone: _____

Name of Mother/Guardian/Spouse: _____

Phone: _____ E-mail: _____

Address: _____

City, State, Zip: _____

Place of Employment: _____

Phone: _____

Name of Father/Guardian/Spouse: _____

Phone: _____ E-mail: _____

Address: _____

City, State, Zip: _____

Place of Employment: _____

Phone: _____

If above persons are not available in the event of an emergency, please contact:

Name: _____ Phone: _____ Name: _____ Phone: _____

Adults authorized to take youth to and from the event:

(You must designate an adult. Please include phone number)

Persons NOT authorized to take youth to and from the event:

2. Health History Information

Name of Primary Physician: _____

Phone: _____

City, State: _____

Medical Insurance Provider: _____

Carrier's Name: _____

Policy or Group Number: _____

Medicaid ID #: _____

Medications taken in the last 30 days: _____

Medications to be continued at event and dose: _____

Special Instruction related to any medications: _____

Any activities participant cannot participate in: _____

	YES	NO	Explain
Serious Illness			
Serious Injury			
Deformity			
Surgery			
Ears, Eyes			
Nose, Sinus			
Teeth/Tonsils			
Chest, Lungs			
Heart Murmur			
Rheumatic Fever			
Appendicitis			
Kidney or Urine			
Menstrual problems			
Hernia			
Back, Limbs, Joints			
Sleepwalking			
Nervous Conditions			
Other (explain)			
Diet Restrictions			

Food Allergies: _____
 Plant Allergies: _____
 Insect/Animal Allergies: _____
 Other Allergies: _____

3. Parent/Minor Signature

This health history is correct so far as I know, and is up to date as of the last 90 days. The person herein described has permission to engage in all prescribed camp activities except as noted. Emergency Authorization: I hereby give permission to the medical personnel selected by the camp officials to order x-rays, routine tests and treatment for me or my child, as in the event I cannot be reached in an emergency. I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for me or my child as named above. I hereby give permission to transport me or my child for medical assistance. I hereby give permission to Boy Scouts of America to use photos, likenesses, and images of me for marketing and publicity purposes. This form may be photocopied for use at camp. I understand that I am responsible for payment of all medical treatments received from non-camp sources. I also give permission for the camp medical staff to administer over-the-counter medications to my child, that the physician has approved on page 2 of this form.

I also give permission for my child to go on trips away from camp premises, and to participate in all camp activities.

***Signature of parent or guardian (or participant if over 18): _____ Date: _____

***Signature of Minor: _____ Date: _____

