

Health History Form

Camper Volunteer

Name: _____

In Case of Emergency, Please Notify:

Name: _____ Home Phone: _____

Cell Phone: _____

Address _____

Second Person to Notify: _____ Home Phone: _____

Cell Phone: _____

Persons allowed to pick child up from camp:

Please check if Cub Scout listed above has been known to have the following:

_____ Convulsions _____ Heart Trouble _____ Allergy to Bee Stings

_____ Fainting Spells

_____ Poison Ivy _____ Other (please describe) _____

Known Allergies _____

Does the Cub Scout listed above have any conditions requiring regular medication?

()yes ()no If yes, please list

medication(s) _____

Should any activities be restricted due to medical reasons?

()yes ()no If yes, please explain

In case of emergency, I understand every effort will be made to contact the persons listed above to notify. In the event I cannot be reached, I hereby give my permission to the licensed health-care professional selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child (or me, if participating in camp).

SIGNATURE _____ DATE _____

(Please print name) _____