Cub Scout Pack 351

Medical Information Form

NAME_______________ PACK #______ BIRTHDATE__________ AGE__________

ADDRESS_______________ CITY/ZIP_______________ PHONE__________

IN CASE OF EMERGENCY NOTIFY:

NAME_______________ RELATIONSHIP_______________

ADDRESS_______________ CITY/ZIP_______________

PHONE (H)__________ (B)__________ OTHER INSTRUCTIONS_______________

HEALTH HISTORY: FAMILY PHYSICIAN_______________ PHONE__________

HAVE OR SUBJECT TO: (CHECK IF YES)

☐ ALLERGY OR REACTION ☐ DIABETES ☐ CONVULSIONS

☐ FAINTING SPELLS ☐ ASTHMA ☐ HEART TROUBLE

☐ ALLERGIC TO BEE STINGS ☐ SPORTS RESTRICTION

☐ OTHER, DESCRIBE_______________

☐ CHECK HERE IF NONE OF THE ABOVE APPLIES.

HAS CUB SCOUT HAD A RECENT DPT INJECTION?__________ WHEN?_______________

HAS DIFFICULTY WITH (CHECK IF YES)

☐ EYES ☐ EARS ☐ NOSE ☐ LUNGS ☐ THROAT

☐ DIGESTION ☐ OTHER, DESCRIBE_______________

ANY CONDITION NOW REQUIRING MEDICATION?__________ MEDICATION__________

ANY RESTRICTION OF ACTIVITY FOR MEDICAL REASONS? EXPLAIN_______________

____

____

DOES PARENT/GUARDIAN HAVE ANY MEDICAL CONDITION WHICH MAY RESTRICT PHYSICAL ACTIVITY WHILE AT CAMP? ☐ YES ☐ NO

IF YES, DESCRIBE_______________

____

SIGNED_______________

(PARENT/GUARDIAN)

DATE_______________