

ADULT

HEALTH HISTORY FORM

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(THIS IS THE ONLY FORM THAT WILL BE ACCEPTED FOR DAY CAMP, CUB/PARENT WEEKENDS AND HOLIDAY WEEKENDS)

A NEW HEALTH HISTORY MUST BE FILLED OUT ANNUALLY

PACK / TROOP (circle one) UNIT # \_\_\_\_\_ CAMP NAME & DATE: \_\_\_\_\_

IDENTIFICATION

NAME: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Home Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name of Spouse or

Relative: \_\_\_\_\_ Home Telephone (\_\_\_\_) \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Work Phone (\_\_\_\_) \_\_\_\_\_ Mobile Phone (\_\_\_\_) \_\_\_\_\_ Pager (\_\_\_\_) \_\_\_\_\_

IF THE PERSON NAMED ABOVE IS NOT AVAILABLE IN THE EVENT OF AN EMERGENCY, NOTIFY:

NAME \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

NAME \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Health History

Family Physician \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Personal Health/Accident insurance carrier \_\_\_\_\_ Policy No. \_\_\_\_\_

IMMUNIZATIONS: Please provide immunization record and date of last inoculation.

DTP/DT/Dt (tetanus): Date \_\_\_/\_\_\_/\_\_\_ MMR: Date \_\_\_/\_\_\_/\_\_\_ Haemophilus Infuenza Type B: Date \_\_\_/\_\_\_/\_\_\_

Other (specify): \_\_\_\_\_

Have or subject to: (check if yes)

Asthma Fainting spells Convulsions Swimming or sport restrictions Insect bites

Diabetes Heart trouble High Blood Pressure Cancer/Leukemia

Current Infectious Diseases Allergies or reaction to any medication, food, other \_\_\_\_\_

Other \_\_\_\_\_ Explain bove \_\_\_\_\_

Have difficulty with: (check if yes) oEyes oEars oNose oThroat oLungs oDigestion

o Any condition now requiring regular prescription or nonprescription medication? Name of medication(s) \_\_\_\_\_

oList any medications to be taken at camp? \_\_\_\_\_

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

Explain \_\_\_\_\_

COMPLETE A SEPARATE FORM FOR EACH CAMP YOU ARE ATTENDING

I hereby give my permission to the physician selected by the designated representative of BSA in charge to secure proper treatment including hospitalization anesthesia, surgery or injections of medication for me. Valid for 1 year from date signed.

Date

Signature

This form will not be returned; a copy is needed for each camp (photocopies are acceptable). Adult form is single-sided.

LAST NAME:

FIRST NAME:

UNIT TYPE & #:

P = pack; T = troop; C = crew

**ADULT**

**HEALTH HISTORY FORM**

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**THIS IS A SINGLE-SIDED FORM.  
THIS SIDE SHOULD BE BLANK.**

**PLEASE REMEMBER TO MAKE A COPY OF YOUR HEALTH FORM  
AND YOUR SCOUT'S HEALTH FORM  
FOR EACH CAMP**