

Parent/Cub Weekend Medical Forms

CUB SCOUT MEDICAL FORM:

NAME _____ BIRTHDATE _____ PACK _____
 ADDRESS: _____
 IN CASE OF EMERGENCY, NOTIFY: NAME _____
 PHONE# _____ OTHER CONTACT _____ PHONE _____
 PERSONAL INS. COMPANY _____ POLICY # _____
 FAMILY DOCTOR _____ PHONE# _____

HEALTH HISTORY:

HAD OR IS SUBJECT TO PROBLEMS WITH: (PLEASE CHECK IF YES)
 EYES ___ EARS ___ NOSE ___ THROAT ___ LUNGS ___ DIGESTION ___ DIABETES ___
 ASTHMA ___ FAINTING SPELLS ___ CONVULSIONS ___ HEART TROUBLE ___ BEE STINGS ___
 ALLERGIES TO FOOD OR MEDS? _____ DESCRIBE _____
 ANY CONDITION REQUIRING REGULAR MEDICATION? _____
 NAME OF MEDICATION _____
 IS THIS MEDICATION WITH HIM? _____ IF NOT, WITH WHO? _____
 OTHER CONDITIONS: _____
 ANY RESTRICTIONS OF ACTIVITY FOR MEDICAL REASONS? _____
 CHECK HERE IF NONE APPLIES: _____

THIS HEALTH HISTORY IS CORRECT TO MY KNOWLEDGE. THE PERSON HEREIN DESCRIBED HAS PERMISSION TO ENGAGE IN ALL ACTIVITIES EXCEPT AS NOTED ABOVE. IN THE EVENT OF AN EMERGENCY AND I CANNOT BE REACHED, THE ADULT LEADER IN CHARGE IS HEREBY GIVEN PERMISSION TO SEEK MEDICAL TREATMENT IF REQUIRED. THE PHYSICIAN HAS PERMISSION TO HOSPITALIZE, SECURE PROPER ANESTHESIA, OR TO COVER INJECTION OR SURGERY FOR MY SON.

SIGNED _____ DATE _____

ADULT HEALTH FORM:

NAME _____ BIRTHDATE _____
 ADDRESS: _____
 INCASE OF EMERGENCY, NOTIFY: NAME _____
 PHONE# _____ OTHER CONTACT _____ PHONE _____
 PERSONAL INS. COMPANY _____ POLICY # _____
 FAMILY DOCTOR _____ PHONE# _____

HEALTH HISTORY:

HAD OR IS SUBJECT TO PROBLEMS WITH: (PLEASE CHECK IF YES)
 EYES ___ EARS ___ NOSE ___ THROAT ___ LUNGS ___ DIGESTION ___ DIABETES ___
 ASTHMA ___ FAINTING SPELLS ___ CONVULSIONS ___ HEART TROUBLE ___ BEE STINGS ___
 ALLERGIES TO FOOD OR MEDS? _____ DESCRIBE _____
 ANY CONDITION REQUIRING REGULAR MEDICATION? _____
 NAME OF MEDICATION _____
 IS THIS MEDICATION WITH HIM? _____ IF NOT, WITH WHO? _____
 OTHER CONDITIONS: _____
 ANY RESTRICTIONS OF ACTIVITY FOR MEDICAL REASONS? _____
 CHECK HERE IF NONE APPLIES: _____

THIS HEALTH HISTORY IS CORRECT TO MY KNOWLEDGE. I CAN ENGAGE IN ALL ACTIVITIES EXCEPT AS NOTED ABOVE. SHOULD I BECOME UNCONSCIOUS, THE ADULT LEADER IN CHARGE HAS PERMISSION TO SEEK MEDICAL TREATMENT. THE PHYSICIAN ENGAGED HAS PERMISSION TO HOSPITALIZE, SECURE PROPER ANESTHESIA, OR TO COVER INJECTIONS OR SURGERY FOR MYSELF.

SIGNED: _____ DATE _____