

Health Information for Cub Scout Day Camp (Youth and Adult)
Central NJ Council, Boy Scouts of America

Please use black ink and print n-e-a-t-l-y

Name _____ Age _____ Pack # _____

Street _____

City/State/Zip _____

Home area code + phone _____

In case of emergency notify: Name _____

Relationship: Parent [] Guardian [] Other _____

Address _____

Phone (area code + number) _____

Other instructions _____

Family physician _____ Area Code + Number _____

Health history - have or subject to: (check if yes)

[] asthma [] fainting spells [] convulsions [] sports restrictions

[] diabetes [] heart trouble [] bleeding disorders

[] allergies or reactions to any medications, food or other

[] allergic to bee stings [] other _____

Explain here if any of the above applies: _____

[] Check here if none of the above applies

Immunizations (must include month and year)

Tetanus Toxoid _____ Polio _____ Mumps _____

Pertussis _____ Diphtheria _____ Measles _____

Rubella _____

Have difficulty with: (check if yes)

[] eyes [] ears [] nose [] throat [] lungs [] digestion

[] Any condition now requiring regular medication? _____

Name of medication _____

[] Is his medication with him? If not, who has it? _____

Any restriction of activity for medical reasons? _____

Explain _____

Is your son physically or emotionally challenged? _____

Explain _____

Adult/parent authorization: This health history is correct so far as I know, and the person herein described has permission to engage in all activities, except as noted by me and the physician. In the event of illness or accident in the course of such activity, I request that measures be instituted without delay as judgment of medical personnel dictates.

Signature _____ Date _____

Adult / Parent, or Guardian

Please submit this form along with your day camp registration form. Scouts will not be permitted to stay at camp without this form. Please keep a copy.