

CUB SCOUT PERSONAL HEALTH AND MEDICAL FORM

IMPORTANT: YOU MUST COMPLETE AND RETURN TO YOUR DEN LEADER

NAME: _____ DATE OF BIRTH: ____/____/____

PARENT'S NAME: _____ DEN: _____

ADDRESS: _____ HOME PHONE: _____

CITY: _____ STATE: _____ ZIP: _____

IN CASE OF EMERGENCY NOTIFY:

NAME: _____ R RELATIONSHIP: _____

PHONE: _____ INSTRUCTIONS: _____

FAMILY PHYSICIAN: _____ PHONE: _____

PERSONAL HEALTH INSURANCE CARRIER: _____

MEDICAL RESTRICTIONS OR DIFFI CULTY:

Allergies Asthma Bee Stings Convulsions Diabetes Fainting Spells
 Heart Condition Sports Restrictions Other Restrictions No Restrictions
 Eyes Ears Nose Throat Digestion Lungs Other

Explain Restrictions or Difficulties: _____

Does Scout take Medication. If so, what kind: _____

IMMUNIZATIONS: (Inoculations should be all current, if not, please indicate the ones that are not)

I give permission for full participation in Pack 141's Cub Scout program, subject to the limitations noted herein. In case of emergency, I understand every effort will be made to contact me or the emergency person. If neither be reached, I hereby give my permission to the medical staff selected by the adult leader in charge to secure proper treatment for my child, including hospitalization, anesthesia, surgery, or injections of medication.

PARENT SIGNATURE: _____ DATE: _____