

**ADULT MED FORM  
FOR WEEKEND TRIPS ONLY  
CLASS 1 PERSONAL HEALTH AND MEDICAL HISTORY**

(To be updated annually by all participants)

To be filled out by adult participant . Please print in ink.

**IDENTIFICATION**

Name \_\_\_\_\_ Date of birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

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

Emergency Contact Names:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Telephone (h) \_\_\_\_\_

Address \_\_\_\_\_ (other) \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Telephone (h) \_\_\_\_\_

Address \_\_\_\_\_ (other) \_\_\_\_\_

Name of personal physician \_\_\_\_\_ Telephone \_\_\_\_\_

Personal health/accident insurance carrier \_\_\_\_\_ Policy No. \_\_\_\_\_

Check all items that apply, **past or present**, to your health history. Explain any " Yes " answers.

**ALLERGIES** : Food, medicines, insects, plants    Yes    No    Explain : \_\_\_\_\_

**GENERAL INFORMATION :**

ADHD (Attention-Deficit Hyperactivity Disorder)	Yes	No	Convulsions/seizures	Yes	No	Hemophilia	Yes	No
Asthma	Yes	No	Diabetes	Yes	No	High blood pressure	Yes	No
Cancer/leukemia	Yes	No	Heart trouble	Yes	No	Kidney disease	Yes	No

Explain : \_\_\_\_\_

Please list ALL medications taken in the 30 days to arrival at the Scouting activity where this form is to be used: \_\_\_\_\_

List any medications to be taken at camp: \_\_\_\_\_

List any physical or behavioral conditions that may affect or limit full participation in swimming, backpacking, hiking long distances, or playing strenuous physical games: \_\_\_\_\_

List equipment needed such as wheelchair, braces, glasses, contact lenses, etc.: \_\_\_\_\_

**Immunizations** : ( Give date of last inoculation.)

Tetanus toxoid	_____	Measles	_____	Polio	_____
Diphtheria	_____	Mumps	_____		_____
Pertussis	_____	Rubella	_____		_____

I give permission for full participation in BSA programs, subject to limitations Noted herein.

**In case of emergency**, I understand every effort will be made to contact my emergency contacts as listed above . In the event they cannot be reached, I hereby give my permission to the licensed health-care practitioner selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for me.

Date \_\_\_\_\_ Signature of adult participant \_\_\_\_\_