

# HEALTH INFORMATION FOR CUB SCOUTS/ADULTS



Name \_\_\_\_\_ Age \_\_\_\_\_ Pack No. \_\_\_\_\_  
 Address \_\_\_\_\_ Camp \_\_\_\_\_ D.O.B \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### IN CASE OF EMERGENCY NOTIFY:

Name \_\_\_\_\_ Relationship: Parent  Guardian   
 Other \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Other Instructions \_\_\_\_\_  
Area Code and Number

Cell Phone \_\_\_\_\_ 2<sup>nd</sup> Cell Phone \_\_\_\_\_  
Area Code and Number Area Code and Number

Family Physician \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

### HEALTH HISTORY

Have or subject to: (check if yes)

- Asthma                       Fainting Spells                       Convulsions                       Swimming or sport restrictions
- Diabetes                       Heart Trouble                       Allergies or reaction to any medication, food, or other
- Other \_\_\_\_\_ Describe \_\_\_\_\_
- Check here if none of above applies                      Physical Handicap \_\_\_\_\_

Have difficulty with: (check if yes)

- Eyes                       Ears                       Nose                       Throat                       Lungs                       Digestion
- Any condition now requiring regular medication? \_\_\_\_\_ Name of medication \_\_\_\_\_
- Is medication with? If not, who has it? \_\_\_\_\_
- Any restriction of activity for medical reasons? \_\_\_\_\_ Explain: \_\_\_\_\_

**IMMUNIZATIONS:** Please write the **date** of last inoculation or disease:

- \*Tetanus Toxoid \_\_\_\_\_  Polio \_\_\_\_\_  Mumps \_\_\_\_\_
- Diphtheria \_\_\_\_\_  Pertussis \_\_\_\_\_  Measles \_\_\_\_\_
- Chicken Pox \_\_\_\_\_  Rubella \_\_\_\_\_

**\* Mandatory immunization within 10 years**

**ADULT PARTICIPANT SIGNATURE** \_\_\_\_\_

OR

**PARENT AUTHORIZATION:** This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed activities, except as noted by me and the physician. In the event I cannot be reached in an emergency, I hereby give permission to the physician, selected by the adult leader in charge, to hospitalize, secure proper anesthesia, or to order injection or surgery for my son. I hereby release all pictures of my child taken by the Northern Star Council camp staff for promotional purposes and programming materials including the Northern Star Council website.

Parent or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Family Health Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Minnesota State Law requires written permission from a minor's parent or guardian in order to shoot a BB gun.

I authorize my son to shoot BB guns under the supervision of trained camp staff.

Parent or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

I **do not** authorize my son to shoot BB guns.