

# 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: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

PHONE: \_\_\_\_\_ INSTRUCTIONS: \_\_\_\_\_

FAMILY PHYSICIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

PERSONAL HEALTH INSURANCE CARRIER: \_\_\_\_\_

## **MEDICAL RESTRICTIONS OR DIFFICULTY:**

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: \_\_\_\_\_