

TROOP 280

PERMISSION SLIP AND MEDICAL FORM

Name _____

Date of Birth _____ Age _____

Name of Parent/Guardian _____ Telephone _____

Home Address _____ City _____ State _____ Zip _____

PHONE NUMBER FOR PICK-UP _____

USE MEDICAL FORM ON FILE Yes No
IF NO FORM IS ON FILE OR CHANGES IN HEALTH EXIST, PLEASE COMPLETE BELOW

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

Allergies: Food, Medicines, Insects, Plants, Animals, etc. Yes No

Explain: _____

General Information	Yes	No		Yes	No		Yes	No
Convulsions/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>			

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 any equipment needed such as wheelchairs, braces, glasses, contact lenses, etc.:

Immunizations (Give date of last inoculation):

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

Name of Personal Physician _____ Phone _____

Personal health/accident insurance carrier _____ Policy Number _____

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. In the event of illness or accident in the course of such activity, I request that measures be instituted without delay as the judgement of medical personnel dictates.

Signature _____ Date _____