HAWK MOUNTAIN COUNCIL
CUB SCOUT CAMPING MEDICAL FORM
Youth and Adult

Week at Camp 1 2 3 4 5 (CIRCLE ONE) | Webelos Extended Session I II (CIRCLE ONE) | Cub Resident Camp Session 1 2 3 4 | Cub Super Weekend

PACK #_____

To be filled out by parent, guardian, or adult participant. Please print in ink.

IDENTIFICATION

Name_____ Date of Birth _____ Age _____ Sex _____

Name of parent or guardian _____ Telephone_____

Home Address _____ CITY _____ STATE ____ ZIP _____

Business Address _____ CITY_____ STATE ____ ZIP_____

If person named above is not available in the event of an emergency, notify

Name_____ Relationship _____ Telephone _____

Name_____ Relationship _____ Telephone _____

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:	Yes	No		Yes	No		Yes	No
Kidney disease	☐	☐	Convulsions/seizures	☐	☐	Hemophilia	☐	☐
High Blood Pressure	☐	☐	Diabetes	☐	☐	Asthma	☐	☐
Cancer/leukemia	☐	☐	Heart trouble	☐	☐			
ADHD (Attention-Deficit Hyperactivity Disorder				☐	☐			

Explain: _____

Please list **ALL** medications taken in the 30 days prior 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 distance, 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 me (if participant is an adult, my spouse or next of kin). In the event I 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 my child (or for me, if participant is an adult).

Date_____ Signature of parent/guardian or adult_____

Note: Some hospitals require the parent/guardian signature to be notarized. Check with your BSA local council.