

PLEASE REPRODUCE FOR EACH PERSON.

2009 Adventure Camp

Registration & Health History Form for Youth & Adults

Complete and submit one form for each Scout and each adult.

Pack # _____ Give this registration form & fees to your den leader.

_____ Session 1: June 12-14, 2009 _____ Session 2: July 17-19, 2009

First come, first served until session filled up

PERSONAL HEALTH AND MEDICAL HISTORY

To be filled out for each youth or adult participant (Please print in ink)

IDENTIFICATION

Name _____ Date of Birth _____ Age _____ Sex _____
Parent/Guardian Name _____ Day Phone _____ Evening Phone _____
Address _____ City _____ State _____ Zip _____
Physician _____ Physician's Phone _____
Emergency Contact Person _____ Contact Phone _____

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

ALLERGIES: Food, medicines, insects, plants, etc. Yes No Explain _____

GENERAL INFORMATION:

	Yes	No		Yes	No		Yes	No
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions/seizures	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>

Explain _____

List any medications to be taken at camp _____
(Must be in original medicine container. Only send needed quantities)

List any physical or behavioral conditions that may affect or limit full participation _____

List equipment needed such as wheelchair, braces, glasses, contact lenses, etc. _____

IMMUNIZATIONS:

	Yes	No		Yes	No		Yes	No		Yes	No
Tetanus toxoid	<input type="checkbox"/>	<input type="checkbox"/>	Measles	<input type="checkbox"/>	<input type="checkbox"/>	Polio	<input type="checkbox"/>	<input type="checkbox"/>	Rubella	<input type="checkbox"/>	<input type="checkbox"/>
Diphtheria	<input type="checkbox"/>	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	<input type="checkbox"/>	Pertussis	<input type="checkbox"/>	<input type="checkbox"/>			

I give permission for full participation in BSA programs, subject to limitations noted herein. I also grant permission to Buffalo Trace Council to use any pictures taken for promotional purposes.

In case of emergency, I understand every effort will be made to contact me (if an adult: my spouse or next of kin). In the event I cannot be reached, I hereby give my permission to the physician selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medications for my child (or for me, if an adult).

Date _____ Signature of parent/guardian or adult participant _____

CAMPER (YOUTH) RELEASE AUTHORIZATION

Authorization is granted for the release of the aforementioned individual to adult employees, staff, volunteers, and camp staff of Buffalo Trace Council, Boy Scouts of America. In addition, to those mentioned above, parents or guardian signing this form, only those individuals listed below are authorized to remove the aforementioned individual from camp. Please notify leaders if potential custody problems exist.

1. _____ 2. _____ 3. _____

Camper Medication Form

Camper: _____ Unit #: _____

Campsite: _____ Camp Dates: _____

1. Medication Required: (To be filled in by parent/guardian)

Name of medication: _____

Reason for taking: _____

Possible common reaction to medication: _____

Dosage: _____ Time(s) of administration: _____

Comments regarding medication: _____

This form has been designed to meet the requirements for the Boy Scouts of America. It offers benefits to the Scout in assuring that the proper medication is given at the proper time, to the leader in knowing exactly what the parent/guardian is requesting the leader to do, and to provide a record that the request was carried out.

NOTE: All prescribed medication must be kept in the original container bearing the physician's name, directions for use, and the patient's name.

2. Prescribing Physician: _____ Phone: _____

Address: _____

3. Permission by Parent/Guardian to Administer Medication:

Name: _____ Name: _____

Indicate "none" in any space above if left blank.

I hereby request that my child be administered his/her prescribed medication at camp by the approved Camp Health Officer or the leader(s) listed above. I understand that the medication at camp will be administered exactly as per the directions as prescribed by the above physician.

Signed: _____ Print Name: _____

Address: _____

Phone: _____ Date: _____

4. Record of Administered Medication:

- a. If given by Camp Health Officer, it will be posted in the medical log.
- b. If given by leader, a record must be kept on reverse side of this form.

5. All medications must be kept in a locked box in the campsite. All medication needing refrigeration will be kept in the Health Office and administered by the Camp Health Officer.

6. This record must be turned into the Camp Health Officer to become a part of the camp's records at the close of camp.

**Reproduce this page & reverse side
for your parents.**