

Name _____ Date of Birth ____/____/____
Last First M. I.

Troop 149 Scout Health History

HEALTH HISTORY

Your Child's/Your Health History is important and will aid in providing health care while he is in the care of troop 149 Leadership. Carefully complete this health form and return it to us as soon as possible.

This form is confidential. No medical information will be released to anyone without your written permission. For insurance purposes, information may be shared with your insurance company. **Please make a copy of this form and retain for your records.**

IDENTIFICATION

Please Print or Type					
Last Name, First Name, MI				Age	
Date of Birth					
Name of Parent or Guardian			Telephone	Cell or Business Phone	
Address					
City		State		Zip	

PERSONAL HISTORY

Check all the items that apply, past or present, to the Scout's/Your health history. Explain for any "Yes" answers below:

Have you had?	No	Yes	Have you had?	No	Yes
Recurrent Headache			Asthma		
Eye Problem			Epilepsy/Seizures		
Ear Problem			Dizziness/Fainting with exercise		
Nose Problem			Head Injury/Concussion		
Throat Problem			Bone/Joint Injuries		
Thyroid Disorder			Stomach/Intestinal Problems		
Heart Murmur/Heart Disease			Diabetes		
Heart Palpitations			Kidney/Bladder Disorders		
High/Low Blood Pressure			ADD/ADHD		
Anemia/Sickle Cell			Chicken Pox/Immunization		
Bleeding Disorders: Hemophilia/Other			Mononucleosis		
Hepatitis			Pneumonia/Bronchitis		
Tuberculosis			Emotional Problems-Specify below:		
Seasonal Allergies/Hay Fever					
Surgeries:					
Hospitalizations:					

If yes, explain _____

Allergies:
Medication Allergies:
Medication currently taking:

Any other disease, illness, past surgeries, permanent disabilities, or explanations of any marked concerns from the list above?

Are you currently being treated by a health care professional? If yes, explain _____

List any physical or behavioral conditions that may affect or limit full participation in swimming, backpacking, hiking long distances, or playing strenuous physical games: _____

IMMUNIZATIONS
 Give date of last dose received

Please Print or Type			
Tetanus Toxoid	Date	OR DPT	Date
Measles	Date	OR MMR	Date
Hepatitis A	Date	Hepatitis B	Date
Varicella	Date	OR Chicken Pox	Date
Polio	Date		

EMERGENCY CONTACTS

Persons to be contacted in case of an emergency. Please list two contacts.		
1. Name	Relationship	Home Phone
Address		Cell or Business Phone
2. Name	Relationship	Home Phone
Address		Cell or Business Phone

INSURANCE INFORMATION

Please Print or Type			
Insurance Co. Name		Member Benefits Phone Number	
Address (to send claims)			
City	State	Zip	
Member I.D. #		Group #.	
Insured's Name (policyholder/responsible party)	Insured's SS#	Insured's Birth Date	Relationship to Insured <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Other

PRIMARY CARE PHYSICIAN

Please Print or Type		
Name		
Address		
City	State	Zip
Phone Number	Fax Number	

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 _____

Date updated _____ Signature of parent/guardian or adult _____

Date updated _____ Signature of parent/guardian or adult _____

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