Burlington County Council Boy Scouts of America

CUB DAY CAMP AND/OR PARENT/SON WEEKEND
PERSONAL HEALTH AND MEDICAL SUMMARY

TO BE FILLED OUT BY PARENT OR GUARDIAN: (PLEASE PRINT:)

Name ____________________________________ Date of Birth _____________ Age_______ Sex _______
Name of Parent or Guardian _____________________________________Telephone (____)_____________
Home Address _______________________________________City_______________________ State_____
Business Address _____________________________________City________________________ State_____
If person 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 Number _______________

Medical Information Past or Present:

Asthma ____Yes ____No	Heart Disease ____Yes ____No	Leukemia ____Yes ____No
Diabetes ____Yes ____No	High Blood Pressure __Yes __No	Cancer ____Yes ____No
Convulsions ___Yes ____No	ADD/ADHD ____Yes ____No	Hemophilia ____Yes ____No

Please explain conditions checked yes ____
____

Allergies: Food ____Yes ____No Plants ____Yes ____No Other ____Yes ____No
Medicines ____Yes ____No Insect Bites ____Yes ____No

Please explain reactions to those checked yes ____
____

Any reason to restrict activities including, but not limited to swimming, long hikes, or strenuous physical games?
____Yes ____No

Please list any conditions limiting full participation (physical or emotional): ______________________________
____

Any reason for medication to be taken at camp? __Yes __No Please list medication to be taken: _____________
____
(Please send ample supply to camp and directions for use)

Any special equipment such as orthopedic or handicap devices, glasses, contacts, dentures? __Yes __No
Please list specific equipment ____
____

The State of New Jersey requires dates for inoculations.

Immunizations:	Date of last Inoculation		Date of last Inoculation
Tetanus, Diphtheria, Pertussis (DPT)	_______________	Tetanus Booster	_____________
Mumps, Measles, Rubella (MMR)	_______________	Polio	_____________

In case of emergency, I understand every effort to contact me will be made. 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 medication for my child. I certify that the above information is correct, and give my child permission to participate in all camp activities, unless otherwise stated.

Date ________________ Signature of Parent of Guardian ____