

To be completed by parent/guardian and returned to the troop leader. PLEASE PRINT.

Name _____ Birth Date _____
Last First Middle Initial

Address _____
Street City State ZIP

Email Address _____

Phone (H) _____ (W) _____ (C) _____

Emergency Contact _____
Name Address Phone

Family Medical/Hospital Insurance Carrier _____
Name Policy or Group Number

Check all that apply:

Allergies*	Chronic Illnesses*	Immunizations			Permission to Administer Medications
			Year Completed	Year Last Booster	
<input type="checkbox"/> Food	<input type="checkbox"/> Heart Defect/Disease	D.T.P.			<input type="checkbox"/> Advil/Ibuprofen
<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Seizures	Diphtheria			<input type="checkbox"/> Tylenol/Acetaminophen
<input type="checkbox"/> Insect Stings	<input type="checkbox"/> Bleeding Disorders	Pertussis			<input type="checkbox"/> Benadryl/Antihistamine
<input type="checkbox"/> Medicine/Drugs	<input type="checkbox"/> Asthma	Tetanus			<input type="checkbox"/> Pepto Bismol/Generic
<input type="checkbox"/> Plants	<input type="checkbox"/> Hypertension	Td			<input type="checkbox"/> Tums/Antacid
<input type="checkbox"/> Pollen	<input type="checkbox"/> Diabetes	Measles			<input type="checkbox"/> Robitussin/Expectorant
<input type="checkbox"/> Animals	<input type="checkbox"/> Musculoskeletal Disorders	Mumps			<input type="checkbox"/> Sudafed/Decongestant
<input type="checkbox"/> Other (specify)	<input type="checkbox"/> Arthritis	Rubella			<input type="checkbox"/> Anti-itch Gel/Cream
	<input type="checkbox"/> Sinusitis	Oral Polio			<input type="checkbox"/> Neosporin/Generic
	<input type="checkbox"/> Ear Infections	Hib			<input type="checkbox"/> Other (specify)
	<input type="checkbox"/> Other (specify)	Hepatitis			
		Tuberculin test			

*Comments (please explain any items that are checked) _____

Other health conditions:

- fainting sleep disturbances bed wetting menstrual cramps
 constipation nosebleeds emotional disturbances other _____

Special medical or dietary regimen to be followed (specify) _____

Permission to treat:

In the event I cannot be reached in an emergency, I hereby give permission to the medical personnel selected by the troop leader to provide routine health care; to administer prescribed medications; to seek emergency medical treatment; to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; to provide or arrange necessary related transportation for my child.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the troop leader to secure and administer treatment, including hospitalization, for the person named above.

This health history is complete and accurate. I know of no reason(s), other than the information indicated on this form, why my daughter should not participate in prescribed activities.

Signature of Parent/Guardian _____ Date _____