

Troop 176
BOY SCOUT HEALTH AND PERMISSION FORM

NAME _____ D.O.B. _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

HEALTH AND ACCIDENT INSURANCE INFORMATION

COMPANY _____ POLICY # _____

BOY'S PERSONAL PHYSICIAN

DR. _____ PHONE # _____

IN CASE OF EMERGENCY PLEASE NOTIFY:

NAME _____ RELATIONSHIP _____ PHONE _____

NAME _____ RELATIONSHIP _____ PHONE _____

NAME _____ RELATIONSHIP _____ PHONE _____

PARENT OF GUARDIAN INFORMATION

NAME _____ HOME PHONE _____

ADDRESS _____ WORK PHONE _____

CITY _____ STATE _____ ZIP CODE _____

PARENTS PERMISSION TO PARTICIPATE

I HEREBY GIVE MY PERMISSION FOR THE ABOVE NAMED CHILD TO PARTICIPATE IN ALL THE SCHEDULED ACTIVITIES OF BOY SCOUT TROOP 176 AND ALSO ALL OF HIS PATROL ACTIVITIES, WITH THE FOLLOWING EXCEPTIONS:

_____ AMONG THE ACTIVITIES THAT HE WILL BE INVOLVED IN ARE: HIKING, CAMPING, COMPETITIVE SPORTS, WATER ACTIVITIES, AND TRANSPORTATION TO AND FROM SOME OF THESE EVENTS. IN THE EVENT OF ACCIDENT OR ILLNESS IN THE COURSE OF THE ACTIVITIES, I REQUEST THAT MEASURES BE INSTITUTED WITHOUT DELAY AS JUDGEMENT OF MEDICAL PERSONNEL DICTATES. I ALSO UNDERSTAND THAT FIRST AID MEASURES WILL BE HANDLED BY THE TROOP LEADERS, AND AUTHORIZE THEM TO REQUEST EMERGENCY MEDICAL TRANSPORTATION TO THE NEAREST MEDICAL FACILITY IF THEY JUDGE IT NECESSARY. I UNDERSTAND THAT MY SON WILL BE ALLOWED TO PARTICIPATE IN ANY EVENT NOT SPECIFICALLY EXCLUDED ABOVE.

THIS PERMISSION EXPIRES 01/31/2006

PARENT OR GUARDIAN _____

WITNESS _____

HEALTH HISTORY
MY SON HAS OR IS SUBJECT TO (CHECK IF YES):

_____ ASTHMA _____ FAINTING SPELLS _____ CONVULSIONS
_____ HEART TROUBLE _____ DIABETES _____ BLEEDING DISORDERS

CHECK HERE IF NONE

MY SON IS ALLERGIC TO: _____

CHECK HERE IF NO ALLERGIES

MY SON REQUIRES THE FOLLOWING SPECIAL CARE OR MEDICATION

NAME OF MEDICATION _____

CHECK HERE IF NONE

MY SON HAS DIFFICULTY WITH:

EYES, EARS, NOSE, THROAT DIGESTION LUNGS
 BED-WETTING SLEEP WALKING

IMMUNIZATIONS:

| | <i>DATE OF LAST INOCULATION</i> | | <i>DATE OF LAST INOCULATION</i> |
|------------|-------------------------------------|----------------------|-------------------------------------|
| TETANUS | _____ | POLIO | _____ |
| MUMPS | _____ | PERTUSSIS | _____ |
| DIPHTHERIA | _____ | MEASLES | _____ |
| RUBELLA | _____ | TUBERCULIN TEST (TB) | _____ |

LAST MEDICAL CHECK UP _____

I CERTIFY THAT THIS INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

PARENT OR GUARDIAN _____ DATE _____