Pack ###, BSA

Medical Information and Emergency Medical Release

Name of Scout _____ Date of Birth _____ Age _____

Name of Parent or Guardian _____ Phone _____

Home Address _____ City _____ State _____ Zip_____

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

Allergies : Food, medicines, insects, plants Yes † No † Explain : _____

General Information :	Yes	No		Yes	No		Yes	No		Yes	No
Asthma	†	†	Convulsions/seizures	†	†	Heart Trouble	†	†	High blood pressure	†	†
Cancer / leukemia	†	†	Diabetes	†	†	Hemophilia	†	†	Kidney disease	†	†
Animal allergies	†	†	Ear, nose or throat infections	†	†	bed-wetting	†	†	Sleepwalking	†	†

Any condition requiring regular medication? _____ Name of medication _____

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

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

Immunizations (give date of last inoculation) :

Tetanus toxoid_____ Pertussis _____ Mumps _____ Polio _____

Diphteria _____ Measles _____ Rubella _____ _____

Personal health/accident insurance carrier _____ Policy # _____

Physician _____ Phone # _____

Dentist _____ Phone # _____

EMERGENCY CONSENT FOR MINORS

(I) (WE) the undersigned, parent(s) of _____, a minor, do certify that the above information is correct so far as I/we know, and hereby authorize the adult leader(s) of Pack ### as agents for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician or surgeon licensed under the provisions of the Medical Practice Act on the medical staff of any accredited hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician, in the exercise of his best judgment, may deem advisable. This authorization is given pursuant to the provisions of section 25.8 of the Civil Code of California. This authorization shall remain in affect for 1 (ONE) year from date of signing unless sooner revoked in writing, delivered to said agent(s).

SIGNATURE OF FATHER _____

DATED: _____ SIGNATURE OF MOTHER _____

SIGNATURE OF LEGAL GUARDIAN _____