

Emergency contact No.:

Allergies:

DOB:

Last name:

Annual BSA Health and Medical Record

Part A GENERAL INFORMATION

Name _____ Date of birth _____ Age _____ Male Female
 Address _____ Grade completed (youth only) _____
 City _____ State _____ Zip _____ Phone No. _____
 Unit leader _____ Council name/No. _____ Unit No. _____
 Social Security No. (optional; may be required by medical facilities for treatment) _____ Religious preference _____
 Health/accident insurance company _____ Policy No. _____

**ATTACH A PHOTOCOPY OF BOTH SIDES OF INSURANCE CARD (SEE PART C).
 IF FAMILY HAS NO MEDICAL INSURANCE, STATE "NONE."**

In case of emergency, notify:

Name _____ Relationship _____
 Address _____
 Home phone _____ Business phone _____ Cell phone _____
 Alternate contact _____ Alternate's phone _____

MEDICAL HISTORY

Are you now, or have you ever been treated for any of the following:

| Yes | No | Condition | Explain |
|-----|----|--|---------|
| | | Asthma | |
| | | Diabetes | |
| | | Hypertension (high blood pressure) | |
| | | Heart disease (i.e., CHF, CAD, MI) | |
| | | Stroke/TIA | |
| | | COPD | |
| | | Ear/sinus problems | |
| | | Muscular/skeletal condition | |
| | | Menstrual problems (women only) | |
| | | Psychiatric/psychological and emotional difficulties | |
| | | Learning disorders (i.e., ADHD, ADD) | |
| | | Bleeding disorders | |
| | | Fainting spells | |
| | | Thyroid disease | |
| | | Kidney disease | |
| | | Sickle cell disease | |
| | | Seizures | |
| | | Sleep disorders (i.e., sleep apnea) | |
| | | GI problems (i.e., abdominal, digestive) | |
| | | Surgery | |
| | | Serious injury | |
| | | Other | |

Allergies or Reaction to:

Medication _____
 Food, Plants, or Insect Bites _____

Immunizations:
 The following are recommended by the BSA. Tetanus immunization must have been received within the last 10 years. If had disease, put "D" and the year. If immunized, check the box and enter the year received.

| Yes | No | Date |
|--------------------------|--------------------------|-------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Tetanus _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Pertussis _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Diphtheria _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Measles _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Mumps _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Rubella _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Polio _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Chicken pox _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis A _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis B _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Influenza _____ |

Exemption to immunizations claimed.
 (For more information about immunizations, as well as the immunization exemption form, see Scouting Safety on Scouting.org.)

MEDICATIONS

List all medications currently used. (If additional space is needed, please photocopy this part of the health form.)
 Inhalers and EpiPen information must be included, even if they are for occasional or emergency use only.

| | | |
|--|--|--|
| Medication _____ Strength _____ Frequency _____ Reason for medication _____ Approximate date started _____ Temporary <input type="checkbox"/> Permanent <input type="checkbox"/> | Medication _____ Strength _____ Frequency _____ Reason for medication _____ Approximate date started _____ Temporary <input type="checkbox"/> Permanent <input type="checkbox"/> | Medication _____ Strength _____ Frequency _____ Reason for medication _____ Approximate date started _____ Temporary <input type="checkbox"/> Permanent <input type="checkbox"/> |
| Medication _____ Strength _____ Frequency _____ Reason for medication _____ Approximate date started _____ Temporary <input type="checkbox"/> Permanent <input type="checkbox"/> | Medication _____ Strength _____ Frequency _____ Reason for medication _____ Approximate date started _____ Temporary <input type="checkbox"/> Permanent <input type="checkbox"/> | Medication _____ Strength _____ Frequency _____ Reason for medication _____ Approximate date started _____ Temporary <input type="checkbox"/> Permanent <input type="checkbox"/> |

NOTE: Be sure to bring medications in the appropriate containers, and make sure that they are NOT expired, including inhalers and EpiPens. You SHOULD NOT STOP taking any maintenance medication.