

CUB SCOUT CAMP HEALTH HISTORY FORM (MA ONLY)

Camp attending: GLD Chelmsford Cub Overnight Weekend Cub Family

Camper's Full Name: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Mother's Name: _____ Home ☎: _____ Work ☎: _____

Father's Name: _____ Home ☎: _____ Work ☎: _____

Name of Physician _____ Phone #: _____

Health Insurance Co. _____ Policy #: _____

Emergency Contact (person to contact should we be unable to reach either parent):

Name: _____ Relationship: _____ Daytime ☎: _____

Does camper have a history of: (check all that apply):

Asthma Bleeding Disorder Infections Diabetes Fainting spells Convulsions Heart Problems

Other (be specific): _____

Athletic or Sports Restrictions: _____

Physical or learning disabilities, which may require extra attention (please specify): _____

Has difficulty with (check all that apply):

Eyes Throat Legs Digestion Nose Ears Feet Lungs Kidneys Back Arms Heart

Other (be specific): _____

Allergies • Food Explain: _____
 • Medication Explain: _____
 • Bee Stings Explain: _____
 • Other Explain: _____

Is there any condition requiring medication: No Yes, explain: _____

Will medications be sent to camp: No Yes Weekly Daily

Name of medication: _____ Dosage Schedule: _____

All medication MUST be in the original prescription bottle with the name of the medication, dosage, and camper's name clearly marked. (If medication is being sent to Camp see reverse side of this form.)

PART A: Immunizations

All campers and staff under 18 years of age have the following immunizations:

Immunization	Dose	Comments	Date	Date	Date	Date	Date
MMR	1						
Measles	2 nd dose						
Polio (OPV or e-IPV)	3	4 doses required if mixed schedule vaccine given					
Diphtheria, Tetanus Toxoids and Pertussis	4 DtaP/DTP/DT/TD	Booster dose of Tetanus/Diphtheria (Td) required if more than 10 years since last dose.					
Hepatitis B	3	For children born after 1/92					

All campers and staff 18 years or older have the following immunizations:

Immunization	Dose	Comments	Date	Date	Date	Date	Date
Measles	2*	*Unless born before 1957					
Mumps	1*	*Unless born before 1957					
Rubella	1						
Diphtheria and Tetanus Toxoids	3	Booster dose of Tetanus/Diphtheria (Td) required if more than 10 years since last dose.					

Doctor's Signature: _____

Or attached certification that dates are accurate.

PART B: Prescription Medications: (Parent & Physician must complete)

This section must be completed by the physician, if prescription medications are indicated on the front side of this form and/or will be administered during camp.

Medication: _____ Prescription number: _____

Dosage: _____ Frequency: _____ Time: _____

Condition requiring medication: _____

Common side effects of medication: _____

Medication may be self administered: Asthma Inhaler, EPI Pen, Other: _____

Date: _____ Signature of Physician: _____

I give the camp permission to administer the medication as indicated above by the physician. I also give the camp nurse permission to administer over the counter medications. These would include, but may not be limited to Tylenol, Advil or Benadryl. Medications indicated under the allergy section of this form will not be administered.

Date: _____ Signature of Parent or Guardian: _____

PART C: Additional Information

Please include any additional information that will assist us in caring for your child or yourself. _____

Important! Please read and Sign:

This health history is correct to the best of my knowledge, and person therein described has permission to engage in all prescribed activities except as noted by a physician or me. If my son or I should acquire an infectious disease prior to camp, I will not send him and will notify Yankee Clipper Council, Inc., in writing of the condition. In the event that I cannot be reached in an emergency, I hereby give my permission to emergency medical personnel to initiate appropriate emergency care. I also give permission to the physician and/or hospital personnel selected by the adult leader in charge to hospitalize, secure proper medical/surgical treatment, give anesthesia, and/or order and administer medication for my son or myself. I also give permission to the camp nurse to administer over the counter medications. These would include but may not be limited to Tylenol, Advil, or Benadryl. Medications indicated under the allergy section of this form will not be administered.

Date: _____ Signature of Parent or Guardian: _____
Or myself if an adult.