

# BSA CLASS 1 PERSONAL HEALTH AND MEDICAL HISTORY

(Annually by all participants)

To be filled out by parent, guardian, or adult participant. Please print in blue ink.

A Class 1 record is required annually for all participants. Includes any event that does not exceed seventy-two consecutive hours, where the level of activity is similar to that normally expended at home or at school, and where medical care is readily available. Examples: day camp, day hike, swimming party, or an overnight camp. Medical information required is a current health history signed by parents or guardian. This form is filled out by participants and kept on file for easy reference.

## IDENTIFICATION

Name \_\_\_\_\_ Date of birth \_\_\_\_\_ Age \_\_\_\_\_

Name of parent or guardian \_\_\_\_\_ Telephone \_\_\_\_\_

Home address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Business address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

If person above is not available in the event of an emergency, notify

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Telephone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Telephone \_\_\_\_\_

Name of personal physician \_\_\_\_\_ Telephone \_\_\_\_\_

Health/accident insurance carrier \_\_\_\_\_ Policy/patient No \_\_\_\_\_

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

**ALLERGIES:** Food, medicines, insects, plants: Yes ( ) No ( ) Explain: \_\_\_\_\_

<b>GENERAL INFORMATION:</b>	Yes	No	Yes	No	Yes	No		
Asthma	( )	( )	Diabetes	( )	( )	High blood pressure	( )	( )
Cancer/leukemia	( )	( )	Heart trouble	( )	( )	Kidney disease	( )	( )
Convulsions/seizures	( )	( )	Hemophilia	( )	( )		( )	( )

Explain: \_\_\_\_\_

List any medications to be taken at camp: \_\_\_\_\_

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, contacts, etc.: \_\_\_\_\_

**IMMUNIZATIONS:** (give date of LAST inoculation or booster)

Tetanus toxoid _____	Measles _____	Polio _____
Diphtheria _____	Mumps _____	Others _____
Pertussis _____	Rubella _____	

Date \_\_\_\_\_ Signature of parent/guardian or adult \_\_\_\_\_

In case of Emergency, I understand every effort will be made to contact me (if an adult, my spouse or next of kin). In the event I cannot be reached, I hereby give my permission to the physician selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child (or for me, if an adult).

Some hospitals require that the parent/guardian signature be notarized. Check with your BSA local council.

BSA form 34414 modified.