



# Pack 76, 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	<input type="checkbox"/> <input type="checkbox"/>	Convulsions/seizures	<input type="checkbox"/> <input type="checkbox"/>	Heart Trouble	<input type="checkbox"/> <input type="checkbox"/>	High blood pressure	<input type="checkbox"/> <input type="checkbox"/>		
Cancer / leukemia	<input type="checkbox"/> <input type="checkbox"/>	Diabetes	<input type="checkbox"/> <input type="checkbox"/>	Hemophilia	<input type="checkbox"/> <input type="checkbox"/>	Kidney disease	<input type="checkbox"/> <input type="checkbox"/>		
Animal allergies	<input type="checkbox"/> <input type="checkbox"/>	Ear, nose or throat infections	<input type="checkbox"/> <input type="checkbox"/>	bed-wetting	<input type="checkbox"/> <input type="checkbox"/>	Sleepwalking	<input type="checkbox"/> <input type="checkbox"/>		

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 \_\_\_\_\_

Diphtheria \_\_\_\_\_ 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 76 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).

DATED: \_\_\_\_\_

Parent or Legal Guardian Signature \_\_\_\_\_