

Health History and Information
2010 Midwest Regional Camporee
Newton Hills Boy Scout Camp

Personal Information Name (last, first, middle)	Age	Birth date	Telephone
Address	City	State/Province	Zip Code
Name of Parent/s: _____ Address	Home Phone	Work	
Person to be notified in case of emergency situation if parent is not available.			
Name			
Address	Home Phone	Work	
Relation to Registrant			
Names of persons other than parent to whom child may be released			
1) _____		2) _____	
3) _____		4) _____	

Medical Information					
Is your child having any of the problems listed below?					
	Yes	No		Yes	No
1. Hay fever, asthma, or wheezing			7. Trouble with passing urine or bowel movements		
2. Eczema or frequent skin rashes			8. Shortness of breath		
3. Convulsions/seizures			9. Speech problems		
4. Heart trouble			10. Dental problems		
5. Diabetes			11. Other		
6. Frequent colds, sore throats, ear aches (4 or more per year)					
Please explain any problem areas identified above:					
Operations or injuries:					

History of emotional or behavioral disturbance			
Medication needed or used (including psychiatric)			Currently being given
<u>Kind</u>	<u>Frequency</u>	<u>Dosage</u>	Yes No
			Yes No
			Yes No
Special conditions to be watched such as allergies (reactions to food, penicillin, or other drugs), bed-wetting, fainting, sleepwalking, etc.			

Immunizations								
	Polio	Mumps	Diphtheria	Tetanus	Pertussis	Measles	Rubella	Other
Date initial immunization was completed								
Date of most recent booster								

Restrictions
Should your child's activity be restricted because of any physical defect or illness? If yes, please explain degree of restriction.

Is there any information that you feel should be passed on to the boy's cadre counselor? If so, please explain.

Signature of Parent of Guardian

I certify that this information is true to the best of my knowledge. I, the undersigned, as legal parent or guardian, understand that every effort will be made to contact me, but do hereby give permission for the camporee medical staff or any licensed physician to render emergency medical care to my son in the event of an emergency.

Signature _____ Date _____

For Camp Use Only		
Date	Ref. No.	Complaint and treatment

NOTE: BE SURE YOUR TETANUS IMMUNIZATION IS UP TO DATE.