HEALTH INFORMATION FOR CUB SCOUTS

Boy Scouts of America

Name ______________________ Age ______ Pack No. ______

Address ______________________

City or Town ______________________ State ______ ZIP ______

IN CASE OF EMERGENCY NOTIFY:

Name ______________________ Relationship: Parent ☐ Guardian ☐

Other ______

Address ______________________

Phone ______________ Other Instructions ______________________
Area code and number

Family Physician ______________________ Phone ______

HEALTH HISTORY

Have or subject to: (check if yes)

☐ Asthma ☐ Fainting spells ☐ Convulsions ☐ Swimming or sport restrictions

☐ Diabetes ☐ Heart trouble ☐ Allergies or reaction to any medication, food, or other

☐ Other ______________ Describe ______________

☐ Check here if none of above applies

Have difficulty with: (check if yes)

☐ Eyes ☐ Ears ☐ Nose ☐ Throat ☐ Lungs ☐ Digestion

☐ Any condition now requiring regular medication? ______ Name of medication ______________

☐ Is his medication with him? If not, who has it? ______________________

☐ Any restriction of activity for medical reasons? ______ Explain: ______________

PARENT AUTHORIZATION: This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed activities, except as noted by me and the physician. In the event cannot be reached in an emergency, I hereby give permission to the physician, selected by the adult leader in charge, to hospitalize, secure proper anesthesia, or to order injection or surgery for my son.

Signature ______________________ Date ______________