2020 Mackinac Island Scout Service Troop 127

TEMPORARY PERSONAL HEALTH AND MEDICAL RECORD

NAME _____ HOME TROOP_____

Height _____ Weight _____ Eye color _____ Hair color _____

PERSONAL HEALTH AND MEDICAL HISTORY

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

IDENTIFICATION: Date of birth_____ Age_____ Sex_____
Name of parent or guardian (Adults Spouse)_____
Telephone_____
Home address _____ City_____ State_____ Zip_____

If person named above is not available in the event of an emergency, notify
Name _____ Relationship_____Telephone_____

Name _____ Relationship_____Telephone_____

Name of personal physician _____Telephone_____

Personal health/accident insurance carrier _____Policy No._____

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: ADHD (Attention-Deficit Hyperactivity Disorder) Yes / No
Convulsions/seizures Yes / No High blood pressure Yes / No Hemophilia Yes / No
Asthma Yes / No Diabetes Yes / No Cancer/leukemia Yes / No
Heart trouble Yes / No Kidney disease Yes / No
Explain:

_____

Please list ALL medications taken currently and 30 days **prior** to MISST training:

_____

List any physical or behavioral conditions that may affect or limit full participation:

_____

LIMITATIONS:
Activity restrictions

_____

Diet restrictions

_____

Comment on any need for medical assistance devices:

_____

IMMUNIZATIONS: (Give date of last inoculation.) (*Hospitals do not allow UP TO DATE*.)
Tetanus toxoid _____Measles _____Polio _____OR DPT _____OR MMR _____
Hepatitis A _____ Hepatitis B _____Varicella _____ OR Chicken pox _____
VISION: Normal _____ Glasses _____ Contacts _____
HEARING: Normal _____Abnormal _____Explain _____

I give permission for full participation in BSA programs, subject to limitations noted herein.

In case of emergency; I understand every effort will be made to contact me (if participant is an adult, my spouse or next of kin). In the event I cannot be reached, I hereby give my permission to the licensed health-care practitioner 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 participant is an adult).

Signature of parent/guardian or adult _____ Date_____