2025 Mackinac Island Scout Service Troop 127

TEMPORARY PERSONAL HEALTH AND MEDICAL RECORD

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

Revised 1/8/2025

NAME ____**HOME TROOP**_____________________

IDENTIFICATION: Date of birth___________________Age________________Sex________________

Height ___________Weight ___________Eye color ___________Hair color ___________

Name of parent or guardian: (adults please list spouse or next of kin)

____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

Please explain and add anything to help us care for your Scout:

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.*) or Exempt:

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 Scouting America 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). Questions? Call Bobbi Bolio-Drews (Health Officer) at 734-323-7708.

Signature of parent/guardian or adult ____Date____________