

To be completed by adult member and returned to the troop leader. PLEASE PRINT.

Name \_\_\_\_\_ Birth Date \_\_\_\_\_  
Last First Middle Initial

Address \_\_\_\_\_  
Street City State ZIP

Email Address \_\_\_\_\_

Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

Emergency Contact \_\_\_\_\_  
Name Address Phone

Family Medical/Hospital Insurance Carrier \_\_\_\_\_  
Name Policy or Group Number

**Check all that apply:**

Allergies*	Chronic Illnesses*	Immunizations
<input type="checkbox"/> Food	<input type="checkbox"/> Heart Defect/Disease	
<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Seizures	Date of last tetanus booster:
<input type="checkbox"/> Insect Stings	<input type="checkbox"/> Bleeding Disorders	Tuberculin test date:
<input type="checkbox"/> Medicine/Drugs	<input type="checkbox"/> Asthma	Result of TB test:
<input type="checkbox"/> Plants	<input type="checkbox"/> Hypertension	
<input type="checkbox"/> Pollen	<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Animals	<input type="checkbox"/> Musculoskeletal Disorders	
<input type="checkbox"/> Other (specify)	<input type="checkbox"/> Arthritis	
	<input type="checkbox"/> Sinusitis	
	<input type="checkbox"/> Ear Infections	
	<input type="checkbox"/> Other (specify)	

\*Comments (please explain any items that are checked) \_\_\_\_\_

Restrictions concerning physical activity \_\_\_\_\_

Special medical or dietary regimen to be followed (specify) \_\_\_\_\_

This health history is complete and accurate. I am able to engage in all prescribed activities except as noted.

Signature \_\_\_\_\_ Date \_\_\_\_\_