

To be completed by parent/guardian 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		Permission to Administer Medications
		Year Completed	Year Last Booster	
<input type="checkbox"/> Food	<input type="checkbox"/> Heart Defect/Disease	D.T.P.		<input type="checkbox"/> Advil/Ibuprofen
<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Seizures	Diphtheria		<input type="checkbox"/> Tylenol/Acetaminophen
<input type="checkbox"/> Insect Stings	<input type="checkbox"/> Bleeding Disorders	Pertussis		<input type="checkbox"/> Benadryl/Antihistamine
<input type="checkbox"/> Medicine/Drugs	<input type="checkbox"/> Asthma	Tetanus		<input type="checkbox"/> Pepto Bismol/Generic
<input type="checkbox"/> Plants	<input type="checkbox"/> Hypertension	Td		<input type="checkbox"/> Tums/Antacid
<input type="checkbox"/> Pollen	<input type="checkbox"/> Diabetes	Measles		<input type="checkbox"/> Robitussin/Expectorant
<input type="checkbox"/> Animals	<input type="checkbox"/> Musculoskeletal Disorders	Mumps		<input type="checkbox"/> Sudafed/Decongestant
<input type="checkbox"/> Other (specify)	<input type="checkbox"/> Arthritis	Rubella		<input type="checkbox"/> Anti-itch Gel/Cream
	<input type="checkbox"/> Sinusitis	Oral Polio		<input type="checkbox"/> Neosporin/Generic
	<input type="checkbox"/> Ear Infections	Hib		<input type="checkbox"/> Other (specify)
	<input type="checkbox"/> Other (specify)	Hepatitis		
		Tuberculin test		

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

**Other health conditions:**

- fainting       sleep disturbances       bed wetting       menstrual cramps  
 constipation       nosebleeds       emotional disturbances       other \_\_\_\_\_

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

**Permission to treat:**

In the event I cannot be reached in an emergency, I hereby give permission to the medical personnel selected by the troop leader to provide routine health care; to administer prescribed medications; to seek emergency medical treatment; to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; to provide or arrange necessary related transportation for my child.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the troop leader to secure and administer treatment, including hospitalization, for the person named above.

This health history is complete and accurate. I know of no reason(s), other than the information indicated on this form, why my daughter should not participate in prescribed activities.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

8/2011; N:\EVERYONE\FORMS - membership services\New Forms 2011-2012\Health and Safety Forms