

Cub Scout Health Form
Texas Trails Council, Boy Scouts of America

Cub Scout's Name _____ Age _____ Birth date _____ Pack # _____
Address _____ City _____ TX _____
Social Security Number _____

In Case of emergency notify:

Name _____ Phone _____ Relationship _____
Address _____ City _____ TX _____
Other Instructions _____
Family Physician _____ Phone _____

Health History

Have or subject to: (Circle if yes)

Eyes	Lungs	Fainting Spells	Sports Restriction
Ears,	Digestion	Heart Trouble	Allergy or reaction to any
Nose,	Asthma	Convulsions	medication, food, etc.
Throat	Diabetes	Swimming Restriction	

Other _____

Describe _____

Any condition now requiring regular medication? _____

Name of medication _____

NOTICE: Without exception, all medication (prescription or non-prescription) must be brought to camp in the original container, with original directions on the container and left with the Camp Health Officer.

Any restriction of activity for medical reasons? _____

Explain _____

Circle here if none of the above applies.

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 I 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 child.

Signature _____ Date _____