

**Troop 73 Registration For 2009**

Scout's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Parent's Name(s): \_\_\_\_\_

Parent's Phone Number(s): \_\_\_\_\_

Comments/Questions: \_\_\_\_\_

Troop Registration of \$36.00 will be taken out of each Scout's account effective January 1<sup>st</sup>, 2009

I give permission for full participation in BSA programs for the year 2009, subject to the limitations noted herein:

**In case of emergency**, I understand every effort will be made to contact me. 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 medicine for my child, at my expense.

I hereby release and agree to hold harmless from liability the chartered organization, local council, Boy Scout of America, and the officers, employees, and volunteers thereof.

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

Medical Comments/Notes: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# CLASS 1 PERSONAL HEALTH AND MEDICAL HISTORY

(To be filled out annually by all participants...It's the Scouts and parents responsibility to update this form throughout the year if any of the answers change or need clarifications....Applies to all Scouting activities held with Troop 73 in the year of 2009)

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

## IDENTIFICATION

Name \_\_\_\_\_ Date of birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Name of parent or guardian \_\_\_\_\_ Telephone \_\_\_\_\_

Home address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Business 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. \_\_\_\_\_

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).

Date \_\_\_\_\_ Signature of parent/guardian or adult \_\_\_\_\_

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) **YES/NO**      Hyperactivity Disorder **YES/NO**

Convulsions/seizures **YES/NO**      Hemophilia **YES/NO**

Asthma **YES/NO**      Diabetes **YES/NO**

High blood pressure **YES/NO**      Cancer/leukemia **YES/NO**

Heart trouble **YES/NO**      Kidney disease **YES/NO**

Explain: \_\_\_\_\_

Please list ALL medications taken in the 30 days **prior** to arrival at the Scouting activity where this form is to be used: \_\_\_\_\_

List any medications to be taken at camp: \_\_\_\_\_

List any physical or behavioral conditions that may affect or limit full participation in swimming, backpacking, hiking long distances, or playing strenuous physical games: \_\_\_\_\_

List equipment needed such as wheelchair, braces, glasses, contact lenses, etc.: \_\_\_\_\_

## Immunizations: (Give date of last inoculation.)

Tetanus toxoid \_\_\_\_\_ Measles \_\_\_\_\_ Polio \_\_\_\_\_

Diphtheria \_\_\_\_\_ Mumps \_\_\_\_\_

Pertussis \_\_\_\_\_ Rubella \_\_\_\_\_