

**Gulf Ridge Council**  
**Cub Scout Day Camp/Twilight Camp 2009**  
**Health History Information**

Complete a separate form for EACH person who will be spending time at Cub Scout Day Camp/Twilight Camp. (This includes the Scout leaders, parents, tot lot siblings, tag-a-long siblings, camp staff -EVERYBODY!)

Scout Camper    Camp Staff    Non-Staff Adult or Youth    Sibling or "Tot"

Name \_\_\_\_\_ Age: \_\_\_\_\_

Address \_\_\_\_\_

State/City/Zip \_\_\_\_\_

Birth Date \_\_\_\_\_ Unit (Pack/Troop) \_\_\_\_\_

Attach your current  
  
photo here.

Required for minors only,  
but to save time in the  
event of a true emergency,  
we recommend this for  
everyone.

**Name:** \_\_\_\_\_

**In Case of Emergency Notify** (please advise these people that you are putting them on this form. Persons listed must be available during this time if needed, i.e. available by phone, in the same local area, etc):

**Contact #1**

**Contact #2**

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Relationship: \_\_\_\_\_

Primary Phone: \_\_\_\_\_

Primary Phone: \_\_\_\_\_

Second Phone: \_\_\_\_\_

Second Phone: \_\_\_\_\_

Cell/Pager: \_\_\_\_\_

Cell/Pager: \_\_\_\_\_

Physician: \_\_\_\_\_

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

Insurance Co: \_\_\_\_\_

Policy/Group#: \_\_\_\_\_

Special Instructions: \_\_\_\_\_

**HEALTH HISTORY**

Does this person have or is he/she subject to: (check if yes)

Asthma    Bleeding disorder    Heart trouble    Convulsions    Diabetes    Fainting spells

Sport restrictions (please list): \_\_\_\_\_

**Allergies:**  Insect bites or stings    Foods \_\_\_\_\_    Medications \_\_\_\_\_

Have difficulty with: (check if yes)  Eyes    Ears    Nose    Throat    Lungs    Digestion

Are there any restrictions for medical reasons?  Yes    No   Describe: \_\_\_\_\_

Is there any condition requiring regular medication?  Yes    No   Name and dose: \_\_\_\_\_

Will medication be brought to camp?  Yes    No   If yes, by whom? \_\_\_\_\_

Instructions needed for medication at camp: \_\_\_\_\_

Date of last tetanus shot: \_\_\_\_\_ Are immunizations current?  Yes    No   If "No" please explain \_\_\_\_\_

**If you or your child requires medication to be taken while at camp, it must be turned into the Camp Health Officer each day by an adult. The medication should be in an individual container with written instructions for dispensing of the medication during the day. Prescription medications must have pharmacy label on them. We recommend you ask your pharmacist to provide you with a specified number of individual labels so you can prepare a disposable container (Ziploc bag) for each day at camp. Medications will not be stored overnight. Campers who require asthma inhalers or epi-pens may carry them. If they are used, a report must be made to the Medical Officer, as soon as practically possible.**

Are there any medical or behavioral conditions that the staff should be aware of? \_\_\_\_\_

I am providing additional medical information for this individual on a separate piece of paper.

**PARENT AUTHORIZATION:** This health history is correct so far as I know, and the person herein described has my permission to engage in all camp activities, except as noted by me and/or the physician. I understand that, in case of emergency, every effort will be made to reach the contact persons, as listed above. If the emergency contacts cannot be reached, I hereby give my permission to the physician selected by the adult leader in charge to administer the immediately necessary medical care to my child.

Applicant (parent/guardian for minors) signature \_\_\_\_\_

Date \_\_\_\_\_ \*\*\*form is NOT complete without signature and date\*\*\*

**Days parent will be at camp:**   **Mon.**   **Tues.**   **Wed.**   **Thurs.**   **Fri.**   (please circle days that apply)