Troop 17 Medical Form

To be filled out by Parent/Guardian or Adult participant. Please print in ink.

IDENTIFICATION Social Security #: _____

Name: _____ Date of birth: _____ Age: _____ Sex: _____

Address: _____ City: _____

State: _____ Zip: _____ Telephone: _____

Name of Parent/Guardian or emergency contact: _____

Telephone: _____ Alternate Telephone: _____

Secondary emergency contact: Name: _____

Relationship: _____ Telephone: _____

Name of personal physician: _____ Telephone: _____

Personal health/accident insurance carrier: _____

Policy Number: _____

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:	Yes	No		Yes	No
Asthma	☐	☐	Heart trouble	☐	☐
Back/spinal problems	☐	☐	High blood pressure	☐	☐
Convulsions/seizures	☐	☐	Orthopedic problems	☐	☐
Diabetes	☐	☐	Respiratory problems	☐	☐

Explain: _____

List any medications currently taken: _____

List any other health concerns: _____

Immunizations: Date of last tetanus shot: _____

I give my permission for full participation in BSA programs, subject to limitations noted herein. In the event of illness or accident in the course of such activity, I request that measures be instituted without delay as the judgement of medical personnel dictates.
In case of emergency, I understand every effort will be made to contact me (if an adult, my spouse or next of kin). In the event, I cannot be reached, I hereby give my permission to the physician selected by the adult leader in charge to secure proper treatment, including but not limited to hospitalization, anesthesia, surgery, or injections of medications for my child (or for me, if an adult)

Signature of parent/guardian or adult participant: _____
Date: _____