

PACK 112

HEALTH AND MEDICAL RECORD FOR **ADULTS**

IDENTIFICATION

Name _____ Date of Birth _____ Age _____ Sex _____

Height _____ Weight _____ Eye Color _____ Hair Color _____ Race _____ Blood Type _____

Scout's Name _____

Home Address _____ City/State _____ Zip _____

Cell Phone _____ Alt Phone _____ Email _____

EMERGENCY CONTACTS

In the event of an emergency, notify:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name of Personal Physician _____ Phone _____

Personal Health/Accident Insurance Carrier _____ Policy No. _____

ALLERGIES

List any known allergies to foods, medications, insects and plants. Please include the type of reaction (hives, swelling, difficulty breathing) and the treatment you prefer (i.e. Epi-Pen, Benedryl).

MEDICAL CONDITIONS

List any known medical conditions, including but not limited to ADHD, asthma, convulsions/seizures, diabetes, heart conditions, high blood pressure, sickle cell disease, etc.

List any physical or behavioral conditions that may affect or limit full participation in backpacking, camping, hiking, or playing strenuous physical games.

List any medical equipment needed such as wheelchair, crutches, glasses, contact lenses, etc. _____

LIMITATIONS

List any activity restrictions: _____

List any dietary restrictions: _____

MEDICATIONS

List all medications, dosages, route (oral, injection, topical), and frequency.

HIPAA ACKNOWLEDGEMENT

I understand that my rights regarding the use and disclosure of my individually identifiable health information and other medical information is protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). In compliance with HIPAA, the information provided on this form is strictly for the use of Pack 112 leaders in the event of an emergency. This personal information will not be distributed, released, or disclosed to anyone not listed as an emergency contact.

CONSENT

I, _____, understand that my involvement and participation in Cub Scouts Programs and
Adult Parent/Guardian's Printed Name

Activities is voluntary and subject to any limitations noted on this form. In case of an emergency or illness, I hereby give permission to the licensed healthcare provider selected by the adult leader in charge to secure proper treatment, including but not limited to examination, X-ray, hospitalization, anesthesia, surgery, and the administration of medications. I further understand that I will be responsible for payment of all charges incurred for any medical treatment.

RELEASE

I hereby agree to hold The Boy Scouts of America and Pack 112, its employees, leaders, agents, representatives, and volunteers harmless from any and all liability, action, causes of action, debts, claims, or demands of every kind and nature whatsoever which may arise by or in connection with the participation of myself or my child in any activities related to the Cub Scouts and Pack 112 Activities.

Signed in the Presence of a Notary: _____
Signature *Date Signed*

WITNESSED

Signature of Witness #1

Printed Name: _____

Title: _____

Signature of Witness #2

Printed Name: _____

Title: _____

Signature of Witness #3

Printed Name: _____

Title: _____

STATE OF FLORIDA

COUNTY OF LEON

This document was sworn to and subscribed before me on this _____ day of _____, 20 ____, by the adult parent/guardian listed above, who is ____ personally known to me or ____ produced identification (type of identification produced _____).

Signature of Notary Public

My Commission Expires on: _____