PACK 112
HEALTH AND MEDICAL RECORD FOR SCOUTS

IDENTIFICATION

Name ____ Date of Birth ________________ Age ______ Sex ______

Height ________ Weight ________ Eye Color _________ Hair Color ___________ Race __________ Blood Type _________

Parent/Guardian ______________________________________ Cell ___________________ Alt ___________________

Home Address _____________________________________ City/State ________________________ Zip ___________

EMERGENCY CONTACTS
If person named above is not available 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).

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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.

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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.

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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, ____________________________________, give permission for my child, _____________________________________,
Parent's Printed Name *Child's Printed Name*

to fully participate in Cub Scouts Programs and Activities, subject to any limitations noted on this form. In case of an emergency or illness, I understand every effort will be made to contact me. In the event I cannot be reached, 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 my child in any activities related to the Cub Scouts and Pack 112 Activities.

Signed in the Presence of a Notary: ____ ____________________
Parent's 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 child's parent listed above, who is ____ personally known to me or ____ produced identification (type of identification produced _______________________________________).

____
Signature of Notary Public

My Commission Expires on: ___________________