

DAY CAMP MEDICAL FORM

NAME _____

Please print or type the following information

Name				Age	
Address		City		State	Zip
Council	Unit No.	Pack	Grade	School	

In case of emergency, Notify

Name		Relationship	
Address			
Home Phone		Another way to reach this person	

INSURANCE

Family Insurance Company	Contract Group #'s
Signature of Parents or Guardian	

HEALTH HISTORY

Indicate any of the following which you have had or currently have:

HISTORY	Yes	No	HISTORY	Yes	No	HISTORY	Yes	No	HISTORY	Yes	No
Have you ever Had:			Have you ever had:			Have you ever had:			Have you ever had:		
Fainting			Asthma			Blurred Vision			Shortness of Breath		
Diphtheria			Diabetes			Headaches			Frequent Urination		
Scarlet Fever			Heart Disease			Fainting			Cough		
Rheumatism			Kidney Disease			Convulsions			Nosebleeds		
Hernia			Tuberculosis			Blackouts			Frequent Sore Throats		
Rheumatic Fever			Jaundice			Painful Joints			Stomach Pains		
Poliomyelitis			Easy Fatigability			Backaches			Epilepsy		
Pneumonia			Cancer/leukemia			Pounding Heart			Bee Stings		

Does this child take any medication prescribed by a physician? If so, please list. _____

Allergies: Food, Medications, Insects, Plants Yes No If yes, please explain _____

-OVER-

Adult
 Youth
 Staff
 Tot

PACK # _____

CAMP _____

RELEASE OF CAMPERS FROM CAMP

Authorization is granted for the aforementioned individual to employees, staff, volunteers and camp staff of Detroit Area Council #262, Boy Scouts of America. In addition, only those individuals listed below are authorized to remove the aforementioned individual from Day Camp during their period of camping – Administrative Rule 11126.2.

No youth will be released to anyone not listed below. Proper I.D. is required.

Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone

*Please Note: Please list spouse above if both parents have not signed authorization below.

The following authorization is required by the Michigan Department of Consumer and Service Industries pursuant to PA 116 of 1973 and administrative rule 127.(1)

The health history contained herein is correct, so far as I know, and the person herein described has permission to engage in all prescribed activities, except as noted me. In the event, I cannot be reached in an emergency, I here by give permission to the physician selected by a designated representative of the Boy Scouts of America to authorize emergency medical or surgery treatment, routine, non-surgical medical care, hospitalize, secure proper anesthesia, or to order injection(s) for my son (or daughter). The person herein described is in good health, has all required immunization current, and I assume the health responsibility for the individual:

*Date _____ Signature _____ Valid for 1 year for date signed.