Class 1 Medical Evaluation

All scouts and adults under 40, participating in approved BSA camping activities need this completed form (it must be updated annually). This includes Day Camps, any Overnight camping programs, and all Resident Camps. It attests to current personal health and medical history by the participant (or parent/guardian). This form expires one year from the date signed.

IDENTIFICATION: To be filled out by parent, guardian or adult participant.
Please print in ink.
Name: _____ Date of Birth: _____Age: _____ Sex: ____
Home Address: _____
City: _____ State: _____ Zip: _____
Name of parent or guardian (if under 18) _____Phone: ( ) _____
Business Address: _____
City: _____ State:_____ Zip:_____
If the person named above is not available in the state of an emergency, notify:
Name: _____ Relationship: _____Phone: ( ) _____
Name: _____ Relationship: _____Phone: ( ) _____
Personal physician: _____ Phone: ( ) _____
Personal health/accident insurance carrier: _____ Policy Number: _____

In case of emergency, I understand every effort will be made to contact those persons named above. In the event that they cannot be reached, I hereby give my permission to the physician selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, or injections.
Date: _____ Signature: _____
(Parent or guardian must sign this form if the Scout is under 18)

Circle all items that apply, past or present, to your health history. Explain any "yes" answers.

Allergies Y / N	Asthma Y / N	Cancer Y / N
Convulsions/seizures Y / N	Diabetes Y / N	Heart Trouble Y / N
Hemophilia Y / N	High Blood Pressure Y / N	Heart Trouble Y / N

Explain: _____

List any medications to be taken at camp: _____
(Medications must be in their original container and be labeled with camper's name and dosage information.)

List any (physical &/or behavioral) conditions that may affect or limit full participation in swimming, camping or physical activities. _____
List equipment needed such as wheelchair, braces, glasses, contact lenses, etc. _____

Immunizations: (give dates of all inoculations or write "disease" in the space provided)

Diphtheria:	Polio:
Hepatitis B: (optional)	Pertussis:
Measles/Mumps/Rubella:	Tetanus toxoid: