Health History

Please print neatly:
Scout Name:_____ **Parent Name:**_____
Address:_____
City:_____ **State:**_____ **Zip:**_____
Health/Accident insurance company:_____
Policy Number:_____

HAVE OR SUBJECT TO (check if yes):

☐ Asthma ☐ Fainting Spells ☐ Convulsions

☐ Diabetes ☐ Heart Trouble ☐ Sleeping Disorders

☐ Allergy to Food/Medication ☐ Any condition that may require Special care, medication, or diet

If you checked yes to any, please explain:_____

_____

☐ Check here if none of the above apply

HAVE DIFFICULTY WITH (check if yes):

☐ Ears, eyes, nose or throat ☐ Digestion ☐ Bed-wetting

☐ Lungs/breathing problems ☐ Sleepwalking

Any condition now requiring medication? _____
Explain:_____
Name of medication:_____
Any restriction of activity for medical reasons?_____

Immunizations: Date of last inoculations
Tetanus:_____ **Polio:**_____ **Mumps:**_____
Measles:_____ **Rubella:**_____ **Pertussis:**_____
Diphtheria:_____

Parent Signature:_____
Date:_____
Home Telephone:_____
Cell Phone:_____