Mawat District Day Camp "HEALTH" Form for *"Cub Scout"* Only

Essential Medical & Emergency Information

This form MUST be completed for day camp registration

Scout's Name:_____Age:____
_____Home Phone #:_____

Father/Guardian:_____Place of Business:_____Wk #_____Cell#_____

Mother/Guardian:_____Place of Business:_____Wk #_____Cell #_____

Emergency Contact:_____Relationship:_____Phone #_____Cell #_____

Physician of choice:_____Group Name:_____Phone #_____

My /Our Scout has difficulty with the following (circle all that applies) ADD ADHD Allergies Asthma Convulsions Diabetes

Digestion Ears Eyes Feet Heart Trouble Lungs Nose Throat Other (explain)_____

Allergic to:_____Phyiscal Restrictions:_____

Date of last Tetanus shot_____Behavioral characteristics we should be aware of_____

Medication taken before camp_____Will this be given again at camp? Yes No

(Please tell us incase of an emergency should occur and EMT's need to know)

Other Medication to be given at camp? Yes No

_____Time(s)_____
_____

If "YES" a Request for administration of medication form MUST be completed and signed by your child's physician. We MUST beable to keep this on file.

NOTE: All medication MUST be turned in DAILY to the CAMP NURSE and will be administered by the nurse ONLY. All meds MUST be CLEARLY labeled w/child's name. Dosage amount, Dosage time, Doctor's name and phone number. It must be in original prescription container.

CERTIFICATION STATEMENT

This health information is correct as far as I know. The Cub Scout herein described has my permission to engage in all camp activities, except as noted by me on the above form. In the event I cannot be reached in an emergency, I hereby give my permission to the physician selected by the adult leader in charge to treat my child as the emergency so requires, whether it be by injection, x ~ ray, anesthesia, hospitalization or surgery.

Signature of Parent/Guardian_____
_____Date:_____2008_____