



**Denver Area Council, B.S.A.
Personal Health and Medical Record—Class 1**



NAME: _____

Instructions: By completing this form, it qualifies as a Class 1 medical history. A Class 1 medical history is a brief health history that does not require a physician's signature. A Class 1 medical history is required for all youth and adults to attend any Denver Area Council event. Youth and adults without a completed medical form will not be allowed to participate and sent home. Please make copies of this form, as it will not be returned to you at the end of the event.

I. Personal and Emergency Contact Information

Name: _____ Date of Birth: _____ Age: _____ Sex: _____
Last Name First Name Middle Initial

Address: _____ City / State: _____ ZIP: _____

Name of Parent / Guardian or Spouse: _____ Phone #: _____

Place of Employment: _____ Phone #: _____

If person named above is not available in the event of an emergency, please contact:

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Persons authorized to take youth from the event (include address and phone):

*Persons **NOT** authorized to take youth from the event (include address and phone):*

II. Health History / Information

Name of Primary Physician: _____

Primary Physician's Phone #: _____

Primary Physician's Address: _____

City / State: _____ ZIP: _____

Name of Dentist / Orthodontist: _____

Dentist / Orthodontist Phone #: _____

Medical Insurance Provider: _____

Carrier's Name: _____

Policy or Group #: _____ Medicaid ID #: _____

Medications taken within last 30 days: _____

Medications to be continued at event (with dosage): _____

Other Special Instructions related to Medications: _____

Check all items of concern or that apply, past or present, to your health history.

- | | |
|--|---|
| <input type="checkbox"/> Frequent Ear Infections | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Convulsions/Epilepsy |
| <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Drug Allergies |
| <input type="checkbox"/> Heart Defect/Disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Bleeding/Clotting Disorders |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Chicken Pox |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Insect Stings |
| <input type="checkbox"/> German Measles | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Other Allergies (list below) |

Explain all items checked above: _____

Problems or diseases not mentioned above: _____

Recurring illness or disability: _____

Operations or serious injuries (dates): _____

III. Parent / Minor Signatures

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted.

Emergency Authorization: I hereby give permission to the medical personnel selected by the camp director to order x-rays, routine tests and treatment for me/or my child, and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for me/or my child as named above. Permission is also given to transport me/or my child for medical assistance. This form may be photocopied for use at camp. I understand that I am responsible for payment of all medical treatments received.

I also give permission for my child to go on trips away from camp premises, and to participate in all camp activities.

*** Signature of parent or Guardian (or participant if over 18): _____ Date: _____

Signature of Witness: _____ Date: _____

*** Signature of Minor: _____ Date: _____

***** YOU MUST HAVE THE ABOVE SIGNATURES TO ATTEND THE EVENT!! *****

UNIT: _____

ACTIVITY: _____