



CREW 500 PERSONAL HEALTH AND MEDICAL HISTORY (Over 21)



Required annually for Adult (over age 21) Venturers.

IDENTIFICATION

Date of This Form _____

Name _____ Date of birth _____ Age ____ Sex ____

Home address _____ Telephone _____

City _____ State ____ Zip _____

In the event of an emergency, notify

Name _____ Relationship _____ Telephone _____

Name _____ Relationship _____ Telephone _____

Name of personal physician _____ Telephone _____

Health/accident insurance carrier _____ Policy/patient No. _____

GENERAL INFORMATION. Have you / this person ever had (circle any that apply):

- | | | | |
|---------------|----------------|----------------------|-----------------|
| Asthma | Diabetes | High blood pressure | Cancer/leukemia |
| Heart trouble | Kidney disease | Convulsions/seizures | Hemophilia |

Use an Inhaler? _____

Allergic to any food, insects, plants or medication? Yes No

Explain all circled/yes answers above: _____

List any physical or behavioral conditions that may affect or limit full participation in swimming, backpacking, hiking long distances, or playing strenuous physical games:

List equipment needed such as wheelchair, contacts, etc.: _____

IMMUNIZATIONS: (give date of last inoculation or booster)

Tetanus toxoid _____ Measles _____ Polio _____

Diphtheria _____ Mumps _____ Pertussis _____

Rubella _____ Others _____

In case of emergency, I understand reasonable efforts will be made to contact me or the other parents or guardians of the child listed above (or if I am an adult, my spouse or next of kin). In the event I am not reached, I hereby consent to any emergency x-ray, anesthetic medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general of special supervision of any physician to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child (or for me, if an adult). This authorization is given in advance of any specific diagnosis, treatment, or hospital care being required. I additionally give authority to the adult leader in charge of any Boy Scouts of America activity to consent on my behalf (if me or the another parent, guardian, spouse or next of kin is not reached as described) to give specific consent to any and all such diagnosis, treatment or hospital care that such physician may deem advisable.

Signature of Venturer _____ Date _____