



CREW 500 PERSONAL HEALTH AND MEDICAL HISTORY (Under 21)



To be filled out by parent or guardian if participant is under 18 years old.
Required annually for all Crew 500 Venturers.

IDENTIFICATION

Date of This Form _____

Name _____ Date of birth _____ Age ____ Sex ____

Name of parent or guardian _____ Telephone _____

Home address _____ City _____ State ____ Zip _____

If person above is not available 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 or 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 _____

Signature of parent/guardian if Venturer under 18 _____ Date _____