



# Pack 318

## Returning Scout Registration

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Scouts Name \_\_\_\_\_ DOB \_\_\_\_\_

Grade \_\_\_\_\_ School Attending \_\_\_\_\_

Parent/Guardian Name 1 \_\_\_\_\_

Parent/Guardian Name 2 \_\_\_\_\_

Address 1 \_\_\_\_\_

Address 2 \_\_\_\_\_

Home Phone 1 \_\_\_\_\_ Home Phone 2 \_\_\_\_\_

Work Phone 1 \_\_\_\_\_ Work Phone 2 \_\_\_\_\_

Cell 1 \_\_\_\_\_ Cell 2 \_\_\_\_\_

Email 1 \_\_\_\_\_

Email 2 \_\_\_\_\_

Wolf \_\_\_\_\_ Bear \_\_\_\_\_ Webelos \_\_\_\_\_

\_\_\_\_ Returning Scout Fee \$50

\_\_\_\_ Boys Life Magazine \$12

Make checks payable to "Pack 318."

Signature of Parent \_\_\_\_\_ date \_\_\_\_\_

Please submit this completed form, registration fee, and newly completed medical form to your den leader.



# PERSONAL HEALTH AND MEDICAL RECORD

## CLASS 1

**Class 1 (update annually for all participants).** Activity: Day camp, overnight hike, or other programs not exceeding 72 hours, with level of activity similar to that of home or school. Medical care is readily available. Current personal health and medical summary (history) is attested by parents to be accurate. This form is filled out by all participants and is on file for easy reference.

### CLASS 1 PERSONAL HEALTH AND MEDICAL HISTORY

(Annually by all participants)

To be filled out by parent, guardian, or adult participant. Please print in ink.

#### IDENTIFICATION

Name \_\_\_\_\_ Date of birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Name of parent or guardian \_\_\_\_\_ Telephone \_\_\_\_\_

Home address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Business address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

If person named above is not available in the event of an emergency, notify

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Telephone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Telephone \_\_\_\_\_

Name of personal physician \_\_\_\_\_ Telephone \_\_\_\_\_

Personal health/accident insurance carrier \_\_\_\_\_ Policy No. \_\_\_\_\_

**In case of emergency,** I understand every effort will be made to contact me (if an adult, my spouse or next of kin). In the event I cannot be reached, I hereby give my permission to the physician selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child (or for me, if an adult).

Date \_\_\_\_\_ Signature of parent/guardian or adult \_\_\_\_\_

**Some hospitals require the parent/guardian signature to be notarized. Check with your BSA local council.**

Check all items that apply, **past or present**, to your health history. Explain any "Yes" answers.

**ALLERGIES: Food, medicines, insects, plants** Yes  No  **Explain:** \_\_\_\_\_

GENERAL INFORMATION:		Yes	No	Yes	No	Yes	No
Asthma	<input type="checkbox"/> <input type="checkbox"/>	Diabetes	<input type="checkbox"/> <input type="checkbox"/>	High blood pressure	<input type="checkbox"/> <input type="checkbox"/>		
Cancer/leukemia	<input type="checkbox"/> <input type="checkbox"/>	Heart trouble	<input type="checkbox"/> <input type="checkbox"/>	Kidney disease	<input type="checkbox"/> <input type="checkbox"/>		
Convulsions/seizures	<input type="checkbox"/> <input type="checkbox"/>	Hemophilia	<input type="checkbox"/> <input type="checkbox"/>				

Explain: \_\_\_\_\_

List any medications to be taken at camp: \_\_\_\_\_

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, braces, glasses, contact lenses, etc.: \_\_\_\_\_

**Immunizations:** (give date of last inoculation)

Tetanus toxoid _____	Measles _____	Polio _____
Diphtheria _____	Mumps _____	_____
Pertussis _____	Rubella _____	_____