



# Health History and Medical Form

**SCOUT ASSOCIATION:** \_\_\_\_\_

**GROUP:** \_\_\_\_\_

**Health History:** The more complete information you provide, the better we are able to work to ensure he/she receives the care he/she needs.

*Please type or write clearly and legibly. Please use Block Letters.*

<b>Name:</b> (First, Last)	<b>Date of Birth:</b>		
<b>Address:</b>	<b>City:</b>	<b>Nation:</b>	
<b>Parent or Guardian:</b>	<b>Phone:</b>	<b>Alternate Phone:</b>	
<b>Parent or Guardian:</b>	<b>Phone:</b>	<b>Alternate Phone:</b>	

**Emergency Contact Information :**

<b>Emergency Contact:</b>	<b>Relationship:</b>
<b>Phone:</b>	<b>Alternate Phone:</b>

**Health History : Please check all that apply and explain checked answers:**

	Diabetes		Sleep disturbances
	Heart Defects/Disease		Rheumatic Fever
	Asthma		Arthritis
	Ear Infections		Hypertension
	Convulsions/Epilepsy/Seizures		Eating Disorders
	Headaches/Migraines		Sinusitis (Sinus Infections)
	Physical Restrictions		Had surgery or hospitalized in the last 5 years
	Currently under doctor's care		
	Other:		
	<b>Please explain checked answers marked above:</b>		

Name: \_\_\_\_\_



**Allergies:** Please list all allergies, the type of reaction and its severity, treatment and date of last reaction. **Include allergies to medications, food, bees, animals, plants, etc.**

Allergies	Reaction/ Severity	Treatment	Date of last Reaction
1.			
2.			
3.			

Other : \_\_\_\_\_

Does he/she suffer from **Anaphylaxis?** Yes No

\*Anaphylaxis is a severe allergic reaction marked by swelling of the throat or tongue, hives, and trouble breathing.

Does he/she carry an inhaler? Yes No

**Medications:** List any medications he/she is currently taken, including dosage schedule and specific instructions for use. Also, please indicate (Yes/No) if he/she is allowed to take the medication on his/her own or if he/she should be monitored by an advisor.

Medication	Purpose	Dosage Schedule	Specific Instructions	Self-Medicate? (Yes/No)
1.				
2.				
3.				
4.				
5.				

**Over-the-Counter Medications:** He/She has permission to take over-the-counter medications in case of accident or injury. Please check all that he/she has permission to take:

- |                            |  |
|----------------------------|--|
| -Tylenol/Acetaminophen     | -Imodium (anti-diarrhea)   |
| -Aspirin (fever reducer)   | -Dramamine (motion sickness prevention)                                |
| -Ibuprofen (pain/swelling) | -Skin Ointments (in case of rash, antibacterial, athlete's foot, etc.) |
| -Benadryl/Antihistamine    | -Other: _____  |
| -Robitussin/expectorant    | _____  |
| -Sudafed/decongestant      | -Other: _____  |
| -Pepto Bismol              | _____  |
| -Tums/antacid              | _____  |

**Special considerations or notes regarding over-the-counter medications:**

Does he/she have a **Special Medical or Dietary Regimen to be followed?** Yes No

If yes, please explain: \_\_\_\_\_  
 \_\_\_\_\_

Have ever had any adverse reactions to general anesthetics? Yes No

If yes, please explain: \_\_\_\_\_

Any other information not covered in this form that is important that Camp Leader know: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Name: \_\_\_\_\_



**This section is to be completed by a physician.**

**Parent/Guardian must complete all the information of the Health History to the best of their knowledge and sign.**

**Medical Examination :**

_____ Nose	_____ Abdomen	Other: _____
_____ Throat	_____ Hernia	_____
_____ Teeth	_____ Musculoskeletal	_____ Appearance/Nutrition
_____ Heart	_____ Skin	_____ General Physical State
_____ Lungs		_____

**Record of Immunization for all :**

**Tetanus immunization is required and must have been received within the last 10 years.**

YES

NOT

Pertussis

Polio

Diphtheria

Other : \_\_\_\_\_

Signature : \_\_\_\_\_

**FOR ALL:**

**HEALTH INFORMATION PRIVACY STATEMENT according, also, with the Italian Law as reported below :**

**“I DATI PERSONALI RIPORTATI IN QUESTA SCHEDA SONO RISERVATI E PROTETTI AI SENSI DELLA LEGGE ITALIANA N°196 del 30.06.2003, art. 11,13,23,24,35, NON POTRANNO ESSERE TRATTATI O GESTITI IN NESSUNA FORMA E POTRANNO ESSERE UTILIZZATI NEL SOLO ED URGENTE INTERESSE DEL TITOLARE E PER IL TEMPO DELL'ATTIVITA' CUI SI RIFERISCE”**

**The Health History and Medical Form is for health care concerns at the specified event only. All records will be handled by staff/volunteers whose job includes processing or using this information for the benefit of the participant. All medical records will be held in limited access by the health care supervisor for the specific event. Access to the information will be limited.**

I have read the above procedures for handling the health and medical form and I agree to the release of any records necessary for treatment.

Signature : \_\_\_\_\_

**FOR YOUNG PERSONS:**

**In caso di malattia o ferite contratte dal minore sopra indicato durante la sua permanenza al campo, concedo/concediamo in anticipo con la presente lettera il consenso affinché gli siano prestate tutte le cure mediche richieste ed anche raggi X, anestesia, processi per diagnosi mediche o chirurgiche ed ogni trattamento considerato necessario al giudizio del medico ed anche l'eventuale ricovero in Ospedale.**

**This Health History and Medical Form for Young Persons is complete and accurate. My child has permission to engage in all prescribed activities, except as noted by me and the examining physician. If it becomes necessary for my child to receive medical treatment I hereby give my general consent to any necessary medical treatment and authorise the Camp Leader (or in their absence one of the Assistant Camp Leaders), to sign any document required by the Hospital Authorities.**

Signature of Parent/Guardian: \_\_\_\_\_

Place and Date: \_\_\_\_\_