



2009 SECTION NE-7B CONCLAVE

"Our Section's 1st Gathering"



June 12-14, 2009
Camp Tri-Mount Scout Reservation

Class 1 Health & Medical Record

A health declaration is required for all participants. Furthermore, each youth member under the age of 18 is required to have a permission slip signed by his parent or legal guardian. Immunization dates are REQUIRED. "Up to Date", "Yes" or other abbreviations are unacceptable and will result in rejection of this form. Please print clearly in ink.

IDENTIFICATION:

Name: _____ Date of Birth: _____ Age: _____ Sex: _____

Name of parent/guardian (YOUTH) or next of kin (ADULT): _____ Phone: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Business Address: _____ City: _____ State: _____ Zip: _____

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

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name of personal physician: _____ Phone: _____

Personal health/accident insurance carrier: _____ Policy Number: _____

PERMISSION & MEDICAL RELEASE

I give permission for full participation in BSA and Order of the Arrow programs, subject to limitations noted herein. 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 injection of medications for my child (or for me, if an adult).

Date: _____ Signature of Parent/Guardian or Adult: _____

GENERAL INFORMATION - Check all items that apply, past or present, to your health history. Please explain any "YES" answers – feel free to continue on the back of this form if you do not have enough room below.

ALLERGIES: Food, Medical, Insects, Plants, Others YES NO Explain: _____

	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	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>			

Explain: _____

List any medications to be taken during the conclave: _____

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

List equipment needed such as wheelchair, braces, glasses, contact lenses, etc.: _____

IMMUNIZATIONS – Please give the date of the last inoculation:

Tetanus _____

Diphtheria _____

Polio _____

Mumps _____

Pertussis _____

Rubella _____

Measles _____