

ACTIVITY HEALTH FORM

Attendee's Name _____ **Youth () Adult ()**
Address _____
City/State/Zip _____
Home Phone _____ Work Phone (if adult) _____
Birth Date _____ Pack _____ District _____

Name of Event _____



PLEASE LET US KNOW THE DATE OF YOUR LAST TETANUS SHOT. THIS IS THE SHOT YOU RECEIVE IF YOU HAVE HAD AN INJURY. THEY ARE GOOD FOR TEN YEARS. DATE OF SHOT _____

Please check if you have any of the following medical problems or if you are on any medication please list them.

<input type="checkbox"/> Medicine Reactions	<input type="checkbox"/> Bee Stings	<input type="checkbox"/> Asthma
<input type="checkbox"/> Digestion Problems	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Seizures	<input type="checkbox"/> Insect Reactions	<input type="checkbox"/> Food Allergies
<input type="checkbox"/> Fainting	<input type="checkbox"/> Ears	<input type="checkbox"/> Sports Restrictions
<input type="checkbox"/> Eyes	<input type="checkbox"/> Nose	<input type="checkbox"/> Non-Swimmer
<input type="checkbox"/> Lung	<input type="checkbox"/> Throat	

Other Problems (please describe) _____
 On Medication (please list) _____

SIGN IF ATTENDEE IS UNDER 18 YEARS OF AGE. This Health History is correct as far as I know. The attendee has my permission, as the Parent/Guardian, to engage in all prescribed activities except those noted. In the event I cannot be reached in an emergency I hereby give permission to the physician selected by the adult leader in charge, to hospitalize, secure proper anesthesia, or order injection or surgery for my child.

Parent/Guardian Signature _____ Date _____

In case of Emergency please contact:

Name _____ Relationship _____ Phone _____
Name _____ Relationship _____ Phone _____