

Health and Medical Record

(For use by all individuals 18 years of age and over)

Detroit Area Council #262 -- Boy Scouts of America

State of Michigan Area 2 Physical

This form **MUST** be printed on yellow paper both sides to meet the State of Michigan requirements

Please print or type the following information

Name				Age	
Address			City		State
Council		Unit No.	Pack	Troop	Post
Zip					

In case of emergency, notify

Name		Relationship			
Address					
Home Phone			Another way to reach this person		

INSURANCE

Family Insurance Company:		Contract/Group #'s			
Signature of Parent or Guardian					

HEALTH HISTORY

Indicate any of the following which you have had or currently have:

HISTORY	Yes	No	HISTORY	Yes	No	HISTORY	Yes	No	HISTORY	Yes	No
Have you ever had:			Have you ever had:			Do you now have:			Do you now have:		
Fainting			Asthma			Blurred Vision			Shortness of Breath		
Diphtheria			Diabetes			Headaches			Frequent Urination		
Scarlet Fever			Heart Disease			Fainting			Cough		
Rheumatism			Kidney Disease			Convulsions			Nosebleeds		
Hernia			Tuberculosis			Blackouts			Frequent Sore Throats		
Rheumatic Fever			Jaundice			Painful Joints			Stomach Pains		
Poliomyelitis			Easy Fatigability			Backaches			Epilepsy		
Pneumonia			Cancer/leukemia			Pounding Heart					

MEDICATIONS

Do you take any medication prescribed by a physician? If so, please list.

Allergies: Food, Medications, Insects, Plants Yes No If yes, please explain: _____

PHYSICAL EXAMINATION

System	Normal	Abn.	System	Normal	Abn.	System	Normal	Abn.
Urinalysis			Throat			Heart		
Vision			Teeth-Cavities			Abdomen		
Blood Pressure			Orthopedic			Hernia		
Pulse Rate			Thyroid			Genitalia		
Ears			Chest			Neurologic		
Nose			Lungs			Muscular		

IMMUNIZATIONS

Please provide immunization record and date of last inoculation

DTP/DT/dT (tetanus)		MMR		Haemophilus influenzae type B	
Other					

TO BE COMPLETED BY A LICENSED PHYSICIAN

I certify that I have examined _____ on _____
Name Date

and find him/her physically fit to participate in all Scouting activities except as noted below. The aforementioned individual has all required immunizations current as required by the State of Michigan and is free of infectious diseases.

RECOMMENDATIONS AND/OR RESTRICTIONS:

Signature: _____ Printed Name of Examiner: _____

Address: _____ Office Phone Number: _____

Answering Service Phone Number/Beeper Number/Alternative Method Contact: _____

NAME

UNIT #

CAMP SITE

The following information is required by the Michigan Department of Consumer and Service Industries pursuant to Public Act 116 of 1973 and administrative rule 109.(4).

Registered position in council:
Position in camp:
Number of years/seasons in summer camp as an adult leader:
Number of years in leadership or short-term weekend Scout camping:

Have you ever been convicted of anything other than a minor traffic violation?

Yes No -- If yes, please explain:

The information contained in this form is correct to the best of my knowledge.

Date _____ Signed _____, Scouter

REFERENCES

As the representative for the chartering organization, I recommend the above-identified individual to serve as a leader of our Scouts in camp.

Unit Comm., Chr., Scout Coord., or Head of Chartered Org.

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Council Representative

Please indicate training received.... (I = Date issued) (E = Date expires)

Life Saving Merit Badge	I		CPR-BLS Certified	I	
BSA Life Guard	I		Safe Swim Defense Training	I	
ARC Basic Water Safety	I		Basic BSA Adult Leader Training	I	
ARC Advanced Swimmer	I		Wood Badge	I	
Water Safety Instructor	E		ARC Multi-Media First Aid	I	
BSA National Camp School	I		ARC Advanced First Aid	I	
ARC Life Guard	E		ARC Life Guard Instructor	E	