

**Health and Medical Record**

(For use by all individuals 17 years of age and under)

Detroit Area Council #262 -- Boy Scouts of America  
State of Michigan Area 2 Physical

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

Name

**Please print or type the following information**

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

**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 Fatiguibility			Backaches			Epilepsy		
Pneumonia			Camcer/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: \_\_\_\_\_

UNIT #

CAMP SITE

**ARRIVAL IN CAMP:**

**DEPARTURE FROM CAMP:**

DAY \_\_\_\_\_ DATE \_\_\_\_\_ DAY \_\_\_\_\_ DATE \_\_\_\_\_

### **RELEASE OF CAMPERS FROM CAMP**

Authorization is granted for the release of the aforementioned individual to employees, staff, volunteers and camp staff of Detroit Area Council #262, Boy Scouts of America. In addition, only those individuals listed below are authorized to remove the aforementioned individual from summer camp during their period of camping - Administrative Rule 11126.2.

Name		Relationship	
Name		Relationship	
Name		Relationship	

\* Please Note: Please list spouse above if both parents have not signed authorization below.

The following authorization is required by the Michigan Department of Consumer and Service Industries pursuant to PA 116 of 1973 and administrative rule 127.(1).

The health history contained herein is correct, so far as I know, and the person herein described has permission to engage in all prescribed activities, except as noted by me and the physician. In the event I cannot be reached in an emergency, I here by give permission to the physician selected by a designated representative of the Boy Scouts of America to authorize emergency medical or surgical treatment, routine, non-surgical medical care, hospitalize, secure proper anesthesia, or to order injection(s) for my son (or daughter). The person herein described is in good health, has all required immunization current, and I assume the health responsibility for the individual:

\*Date \_\_\_\_\_ Signature: \_\_\_\_\_ Valid for 1 year from date signed.  
Parent or Guardian

\*Date \_\_\_\_\_ Signature: \_\_\_\_\_ Valid for 1 year from date signed.  
Parent or Guardian

\*Date \_\_\_\_\_ Signature: \_\_\_\_\_ Valid for 1 year from date signed.  
Parent or Guardian