

**CLASS 1 MEDICAL FORM FOR CUB SCOUTS AND CUB PARENTS  
FOR USE AT DAY CAMP AND FUNPACKS WEEKENDS**

**Please complete camp program you are attending:**

**Day Camp at \_\_\_\_\_ (location) Date of camp: \_\_\_\_\_**

**FunPack Weekend at Camp Hinds Dates \_\_\_\_\_**

**Adult \_\_\_\_\_ Youth \_\_\_\_\_**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Pack # \_\_\_\_\_

Address \_\_\_\_\_ Adult Scouting Position \_\_\_\_\_

City/Town \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**IN CASE OF EMERGENCY NOTIFY:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Other way to reach this person \_\_\_\_\_

Physician's Name \_\_\_\_\_ Physician's Phone \_\_\_\_\_

**HEALTH HISTORY (Have you had: mark "past" or "now" or leave blank)**

Sinus Trouble \_\_\_\_\_ Asthma \_\_\_\_\_ Fainting Spells \_\_\_\_\_

Rheumatic Fever \_\_\_\_\_ Earache/Infection \_\_\_\_\_ Diabetes \_\_\_\_\_

Epilepsy \_\_\_\_\_ Tuberculosis \_\_\_\_\_ Frequent Diarrhea \_\_\_\_\_

Kidney Disease \_\_\_\_\_ Heart Trouble \_\_\_\_\_ For Women:

Hay Fever \_\_\_\_\_ Severe Stomachaches \_\_\_\_\_ Menstrual Problems \_\_\_\_\_

Know allergies or reactions to any medications? \_\_\_\_\_

Do you tire easily? \_\_\_\_\_ Do you get out of breath easily? \_\_\_\_\_

Have you had more than a brief illness or injury in the past year? \_\_\_\_\_

If so, what? \_\_\_\_\_

Any condition now requiring regular medication or treatment? \_\_\_\_\_

Operations or serious injuries (dates) \_\_\_\_\_

Any restriction of activity for medical reasons? \_\_\_\_\_

Explain \_\_\_\_\_

**Immunizations**

**Date of Last Inoculation**

Tetanus Toxin	_____
Diphtheria	_____
Mumps	_____
Polio	_____
Other	_____

**Per State of Maine regulations:  
"Up to date" is not acceptable.  
Please list month and year of last  
inoculation.**

**PARENT AUTHORIZATION**

*This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed activities, except as noted. In the event I cannot be reached in an emergency, I give permission to the physician, selected by the adult leader in charge, to hospitalize, secure proper anesthesia or order injection or surgery in an emergency situation for my son or myself.*

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Parent or Guardian**

**( ) We have accident coverage with** \_\_\_\_\_

**Name of Company**

**Policy #**