MEDICAL INFORMATION / INFORMED CONSENT

B.S.A. "Personal Health and Medical Record, Class 1, 2 or 3" may replace Section 1 below.

Please Print all entries Name:_____
First name M.I. Last name

Full Address_____

Participant or parent telephone:(___)_____(___)_____(___)_____
Home Work Mobile/cell

Scout unit or Affiliation:_____ Age:_____ Sex (M/F):_____

Section 1 (Use back of page when additional space is needed)

Family emergency contact:_____Phone:(___)_____

Alternate emergency contact:_____Phone:(___)_____

Personal physician:_____Phone:(___)_____

Personal health/accident insurance carrier:_____Policy no.:_____

List known allergies (food, medicines, insects, plants):_____
List current medications and condition they cover:_____
List health equipment used (e.g. glasses, contacts, braces, removable teeth):_____

Have you had or do you now have (circle if yes): ADHD Asthma Cancer/Leukemia Diabetes
Heart trouble Hemophilia High blood pressure Kidney disease Current pregnancy Seizures/convulsions.
Explain:_____
_____

Date of last Tetnus inoculation: _____
Have you ever had any other serious disease or surgery? (If yes, explain and include date.)_____
_____

Do you have any other medical conditions of which we should be aware, or which may limit your level of physical activity?_____
_____

Section 2

I am not under the influence of any chemical substance including alcohol. Understanding that any physical activity involves risk of injury, I understand that my participation in the Boy Scouts of America, Alamo Area Council Inc., COPE program is entirely voluntary. I give permission for full participation in Project COPE, subject to limitations noted above. I release Boy Scouts of America, Alamo Area Council Inc., its employees, staff, and COPE facilitators from any claims or liability arising out of my participation.

To the {Parent/Guardian} [Participant]: In case of emergency, I understand every effort will be made to contact {me} [my spouse]. In the event that person cannot be reached, I hereby give my permission to the licensed health care practitioner selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my {child}[self].

_____
Signature Date

*If the participant is under age 18, their parent or guardian must also sign below.

_____
Parent or Guradian Signature Date *Revised 6/04*