

**YOUTH PERSONAL HEALTH HISTORY
CENTRAL NJ COUNCIL, BSA**

PRINT IN INK. TO BE FILLED OUT BY PARENT OR GUARDIAN.

SCOUT'S NAME _____

BIRTHDATE _____ AGE _____

NAME OF PARENT OR GUARDIAN _____

DAYTIME AREA CODE AND TELEPHONE _____

HOME AREA CODE AND TELEPHONE _____

STREET ADDRESS _____

CITY _____ STATE/ZIP _____

CHECK ALL ITEMS THAT APPLY, PAST OR PRESENT, TO YOUR HEALTH HISTORY. EXPLAIN ANY "YES" ANSWERS.

ALLERGIES: FOOD, MEDICINES, INSECTS, PLANTS YES _____ NO _____

EXPLAIN: _____

GENERAL INFORMATION:

	YES	NO		YES	NO
ASTHMA			CONVULSIONS/ SEIZURES		
HEART TROUBLE			HIGH BLOOD PRESSURE		
HEMOPHILIA			KIDNEY DISEASE		
CANCER/LEUKEMIA			DIABETES		

LIST ANY MEDICATIONS TO BE TAKEN AT CAMP: _____

LIST ANY PHYSICAL OR BEHAVIORAL CONDITIONS THAT MAY EFFECT OR LIMIT FULL PARTICIPATION IN SWIMMING, BACKPACKING, HIKING LONG DISTANCES, OR PLAYING STRENUOUS PHYSICAL GAMES:

LIST EQUIPMENT NEEDED SUCH AS WHEELCHAIR, BRACES, GLASSES, CONTACT LENSES, ETC.

IMMUNIZATIONS (GIVE DATE OF LAST INOCULATION OR OCCURANCE):

TETANUS _____ PERTUSSIS _____ MUMPS _____ POLIO _____

DIPHTHERIA _____ MEASLES _____ RUBELLA _____

NAME OF PERSONAL PHYSICIAN _____

AREA CODE AND TELEPHONE NO. _____

PERSONAL HEALTH/ACCIDENT INSURANCE CARRIER _____

POLICY NO. _____

PARENT AUTHORIZATION:

THIS HEALTH HISTORY IS CORRECT AS FAR AS I KNOW, AND THE PERSON HEREIN DESCRIBED HAS PERMISSION TO ENGAGE IN ALL PRESCRIBED ACTIVITIES, EXCEPT AS NOTED BY ME. IN THE EVENT OF ILLNESS OR ACCIDENT IN THE COURSE OF SUCH ACTIVITY, I REQUEST THAT MEASURES BE INSTITUTED WITHOUT DELAY AS THE JUDGMENT OF MEDICAL PERSONNEL DICTATES.

PARENT OR GUARDIAN'S PRINTED NAME _____

SIGNATURE _____ DATE _____

**ADULT PERSONAL HEALTH HISTORY FORM
CENTRAL NJ COUNCIL, BSA**

PRINT IN INK. FOR USE BY ANYONE 18 YEARS AND OLDER.

YOUR NAME _____ BIRTHDATE _____ AGE _____

YOUR STREET ADDRESS _____

CITY _____ STATE/ZIP _____

EMERGENCY CONTACT'S NAME & RELATIONSHIP _____

CONTACT'S HOME AREA CODE AND TELEPHONE _____

CONTACT'S BUSINESS AREA CODE AND TELEPHONE _____

CHECK ALL ITEMS THAT APPLY, PAST OR PRESENT, TO YOUR HEALTH HISTORY. EXPLAIN ANY "YES" ANSWERS.

ALLERGIES: FOOD, MEDICINES, INSECTS, PLANTS YES _____ NO _____

EXPLAIN: _____

GENERAL INFORMATION:

	YES	NO		YES	NO
ASTHMA			CONVULSIONS/ SEIZURES		
HEART TROUBLE			HIGH BLOOD PRESSURE		
HEMOPHILIA			KIDNEY DISEASE		
CANCER/LEUKEMIA			DIABETES		

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LIST EQUIPMENT NEEDED SUCH AS WHEELCHAIR, BRACES, GLASSES, CONTACT LENSES, ETC.

IMMUNIZATIONS (GIVE DATE OF LAST INOCULATION OR OCCURANCE):

TETANUS _____ PERTUSSIS _____ MUMPS _____

POLIO _____ DIPHTHERIA _____

MEASLES _____ RUBELLA _____

NAME OF YOUR PERSONAL PHYSICIAN _____

PHYSICIAN'S AREA CODE AND TELEPHONE NO. _____

YOUR PERSONAL HEALTH/ACCIDENT INSURANCE CARRIER _____

INSURANCE POLICY NO. _____

YOUR PERSONAL AUTHORIZATION:

THIS HEALTH HISTORY IS CORRECT AS FAR AS I KNOW, AND THE PERSON HEREIN DESCRIBED HAS PERMISSION TO ENGAGE IN ALL PRESCRIBED ACTIVITIES, EXCEPT AS NOTED. **IN THE EVENT OF ILLNESS OR ACCIDENT IN THE COURSE OF SUCH ACTIVITY, I REQUEST THAT MEASURES BE INSTITUTED WITHOUT DELAY AS THE JUDGMENT OF MEDICAL PERSONNEL DICTATES.**

YOUR PRINTED NAME _____

YOUR SIGNATURE _____ DATE _____