

SCOUT HEALTH RECORD FORM

A completed Scout Health Record Form must be on file with the Scout Office prior to each child beginning class. Completed Scout Health Record Forms can be faxed to 713-639-4681, emailed as an attachment to: scouts@hmns.org, or mailed or dropped off to: Scouts, HMNS, 5555 Hermann Park Drive, Houston, TX 77030.

1. SCOUT INFORMATION PLEASE PRINT NEATLY

Scout's Name _____
Date of Birth _____ M/F _____ Contact Parent/Guardian _____
Address _____
City _____ State _____ Zip Code _____
Emergency Phone #1 _____ Emergency Phone #2 _____

2. MEDICAL INSURANCE INFORMATION

This scout is covered by family medical/hospital insurance. YES _____ NO _____
Insurance Company _____
Policy Number _____
Subscriber _____
Insurance company phone number: _____

3. HEALTH CARE PROVIDERS

Name of scout's primary doctor(s): _____ Phone _____
Name of dentist(s): _____ Phone _____
Name of orthodontist(s): _____ Phone _____

4. ALLERGIES AND DIET

____ No known allergies.
____ This scout is allergic to: Food _____ Medicine _____ The environment (insect stings, hay fever, etc.) _____ Other _____
Please describe what the scout is allergic to and the reaction seen _____
In the case of food allergies, does the scout eat a regular diet? YES _____ NO _____ If no, please describe special food needs. _____
Please indicate action to be taken and any medication to be administered in case of allergic reaction (mild or severe) _____

Does the scout have an EpiPen? YES _____ NO _____

5. RESTRICTIONS

____ I have reviewed the program of the class and feel the scout can participate without restrictions.
____ I have reviewed the program of the class and feel the scout can participate with the following restrictions or adaptations.
(Please describe) _____

6. IMMUNIZATION HISTORY

Provide the month and year for each immunization.

A copy of your child's immunization record from your health-care provider is also acceptable. Please attach to this form.

Diphtheria, tetanus, pertussis (DTaP) or (Tdap): Dose 1 _____ Dose 2 _____ Dose 3 _____ Dose 4 _____ Dose 5 _____
Tetanus Booster (dT) or (Tdap): Most Recent Dose _____
Mumps, measles, rubella (MMR): Dose 1 _____ Dose 2 _____ Most Recent Dose _____
Polio (IPV): Dose 1 _____ Dose 2 _____ Dose 3 _____ Dose 4 _____ Most Recent Dose _____
Haemophilus influenza type B (HIB): Dose 1 _____ Dose 2 _____ Dose 3 _____ Dose 4 _____
Pneumococcal (PCV): Dose 1 _____ Dose 2 _____ Dose 3 _____ Dose 4 _____
Hepatitis B: Dose 1 _____ Dose 2 _____ Dose 3 _____
Hepatitis A: Dose 1 _____ Dose 2 _____
Varicella (chicken pox): Dose 1 _____ Dose 2 _____
Meningococcal meningitis (MCV4): Dose 1 _____
Tuberculosis (TB) test: Date: _____ Negative _____ Positive _____

My scout has been fully immunized and I have provided immunization record information.

Signature of Custodial Parent/Guardian _____
Date _____ Relationship to Scout _____

7. MENTAL, EMOTIONAL, AND SOCIAL HEALTH

Has the scout:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? YES _____ NO _____
2. Ever been treated for emotional or behavioral difficulties or an eating disorder? YES _____ NO _____
3. During the past 12 months, seen a professional to address mental/emotional health concerns? YES _____ NO _____
4. Had a significant life event that continues to affect the scout's life? YES _____ NO _____

Please explain YES answers: _____

Please provide in the space below any additional information about the scout's health that you think important or that may affect the scout's ability to fully participate in the scout program. Attach additional information if needed.

8. PARENT/GUARDIAN AUTHORIZATION FOR HEALTH CARE:

This health history is correct and accurately reflects the health status of the scout to whom it pertains. Scout has permission to participate in all class activities except as noted by me/or an examining physician. If I cannot be reached in an emergency, I give permission to the camp to get scout to an emergency room in the most expedient manner possible. Additionally, I give permission for a physician selected by the camp to hospitalize and secure proper treatment for scout, including but not limited to ordering injections, anesthesia, surgery, x-rays and other tests related to the health of scout. I understand this information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of scout's health record from providers who treat scout and these providers may talk with the program's staff about scout's health status in the event of an emergency.

Signature of Custodial Parent/Guardian _____ Date _____ Relationship to scout _____