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 _____ (First)(Middle) (Last)

Date of Birth _____ M/F _____ Contact Parent/Guardian _____

Address _____

City _____ StateZ_____ ip 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.)O____ ther _____

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 childs immunization record from your health-care provider is also acceptable. Please attach to this form.

Diphtheria, tetanus, pertussis (DTaP) or (TdaP): Dose 1D_____ ose 2D_____ ose 3D_____ ose 4D_____ ose 5_____

Tetanus Booster (dT) or (TdaP): Most Recent Dose _____

Mumps, measles, rubella (MMR): Dose 1D_____ ose 2M_____ ost 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 _____