

# SCOUT HEALTH RECORD FORM

A completed Scout Health Record Form must be on file with the Scout Office prior to each scout beginning class. Completed Scout Health Record Forms can be faxed to 713-639-4681, emailed as an attachment to: [scouts@hms.org](mailto:scouts@hms.org) or mailed or dropped off to: Summer Scouts at HMNS, Education Office, Houston Museum of Natural Science, 5555 Hermann Park Drive, Houston, TX 77030-1799.

## 1. SCOUT INFORMATION Please Print Neatly

Scout Name \_\_\_\_\_  
(First) (Middle) (Last)

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 Co 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.

COVID-19 Vaccine \_\_\_\_\_ Dose 2 \_\_\_\_\_ FLU Vaccine in Fall 2020 \_\_\_\_\_ or Spring 2021 \_\_\_\_\_

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 (MOV4): 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 camper'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 scout program to get scout to an emergency room in the most expedient manner possible. Additionally, I give permission for a physician selected by the scout program 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 scout staff. I give permission to photocopy this form. In addition, the scout program has permission to obtain a copy of scout's health record from providers who treat scout and those 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 \_\_\_\_\_