DO NOT STAPLE TO THIS SIDE OF FORM

Indian Drum # 152 Registration/Health Form

Section C-2B Conclave - April 22, 23, 24, 2005 - Camp Rotary

PLEASE FILL OUT THIS PAGE COMPLETELY

Name ______________________ Date of Birth ______________ Unit __________

Address ______________________ Phone ______________

City ______________________ State ________ Zip __________

IN CASE OF EMERGENCY NOTIFY:

Name ______________________ Relationship: Parent ☐ Guardian ☐ Other __________

Address ______________________ Phone (H) ______________

(W) ______________

Health History

HAVE OR SUBJECT TO: (CHECK IF YES) Check here if none applies ☐

☐ asthma ☐ fainting spells ☐ swimming or sports restrictions ☐ convulsions

☐ diabetes ☐ heart trouble ☐ allergy/reaction to any medication ☐ other __________

HAVE DIFFICULTY WITH: (CHECK IF YES)

☐ eyes, ears, nose, throat ☐ digestion ☐ bed-wetting

☐ lungs ☐ sleepwalking

HAVE HAD: (CHECK IF YES)

☐ measles ☐ chicken pox ☐ German measles

☐ mumps ☐ whooping cough ☐ diphtheria

Any conditions now requiring medication? __________ Name of medication ______________________

Any restriction of activity for medical reasons? Explain: ______________________

____

Any dietary restrictions? Explain: ______________________

IMMUNIZATIONS	Date of last inoculation				
tetanus toxoid	_____	measles	_____	polio	_____
German measles	_____	mumps	_____	diphtheria	_____

The person named on this form is covered by the following medical insurance: ______________________

Group No. ______________ Policy No. ______________ Ident No. ______________

Registration Information

☐ Youth ☐ Adult

PARENTS AUTHORIZATION

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed activities, for the event indicated above, except as noted by me and the physician. In the event I cannot be reached in an emergency, I hereby give permission to the Physician selected by a designated representative of the Boy Scouts of America to authorize emergency medical or surgical treatment, routine, non-surgical medical care, hospitalize, secure proper anaesthesia, or to order injection(s) for my son. I agree to comply with the registration policies of Section C-2B, Lake Huron Area Council - Boy Scouts of America.

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Signature of Parent or guardian

ADULTS AUTHORIZATION

In the event that I am injured and rendered unconscious, I hereby give permission to the Physician selected by a designated representative of the Boy Scouts of America to authorize emergency medical or surgical treatment, routine, non-surgical medical care, hospitalize, secure proper anaesthesia, or to order injection(s). I agree to comply with the registration policies of Section C-2B, Lake Huron Area Council - Boy Scouts of America.

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Signature of participant over 18 yrs. of age.

Complete and sign this form

Additional Registration and payment Information on Reverse Side