

Participant Medical Information

v2

Participant name: _____

Scout Group: _____ **Date of Birth:** _____

Emergency Contact: _____ Phone: _____

Physician's Name: _____ Phone: _____

Insurance Held: **Yes / No** Insurance Details: _____

Does the participant have any **allergies**? If so, list & indicate mild/severe/life-threatening:

Does the participant.... need to carry an Epi Pen ? **Yes / No**

use a CPAP machine ? **Yes / No** use an Inhaler ? **Yes / No**

Does the participant have any **medical conditions, diseases, or disorders**? If so, list:

Does the participant require any **special care, medication or diet**? If so, provide details:

Does the participant have any **restrictions or limitations** on participation in any activities?

If so, list: _____

Date of **most recent tetanus shot** (month/year) _____

May **over-the-counter medications** be given to the participant based on medical staff advice? **Yes / No** Is the participant a **Swimmer** or **Non-Swimmer** ?

I give consent for participant's medical information to be shared with emergency personnel if an emergency should arise.

X _____
Parent Signature (if participant under 18)

X _____
Participant Signature

Date