

# MEDICAL INFORMATION / INFORMED CONSENT

B.S.A. "Personal Health and Medical Record, Class 1, 2 or 3" may replace Section 1 below.

Please Print all entries Name: \_\_\_\_\_

First name

M.I.

Last name

Full Address \_\_\_\_\_

Participant or parent telephone: (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

Home

Work

Mobile/cell

Scout unit or Affiliation: \_\_\_\_\_ Age: \_\_\_\_\_ Sex (M/F): \_\_\_\_\_

## Section 1 (Use back of page when additional space is needed)

Family emergency contact: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Alternate emergency contact: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Personal physician: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Personal health/accident insurance carrier: \_\_\_\_\_ Policy no.: \_\_\_\_\_

List known allergies (food, medicines, insects, plants): \_\_\_\_\_

List current medications and condition they cover: \_\_\_\_\_

List health equipment used (e.g. glasses, contacts, braces, removable teeth): \_\_\_\_\_

Have you had or do you now have (circle if yes): ADHD Asthma Cancer/Leukemia Diabetes  
Heart trouble Hemophilia High blood pressure Kidney disease Current pregnancy Seizures/convulsions.  
Explain: \_\_\_\_\_

Date of last Tetnus inoculation: \_\_\_\_\_

Have you ever had any other serious disease or surgery? (If yes, explain and include date.) \_\_\_\_\_

Do you have any other medical conditions of which we should be aware, or which may limit your level of physical activity? \_\_\_\_\_

## Section 2

I am not under the influence of any chemical substance including alcohol. Understanding that any physical activity involves risk of injury, I understand that my participation in the Boy Scouts of America, Alamo Area Council Inc., COPE program is entirely voluntary. I give permission for full participation in Project COPE, subject to limitations noted above. I release Boy Scouts of America, Alamo Area Council Inc., its employees, staff, and COPE facilitators from any claims or liability arising out of my participation.

**To the {Parent/Guardian} [Participant]:** In case of emergency, I understand every effort will be made to contact {me} [my spouse]. In the event that person cannot be reached, I hereby give my permission to the licensed health care practitioner selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my {child}[self].

Signature \_\_\_\_\_

Date \_\_\_\_\_

\*If the participant is under age 18, their parent or guardian must also sign below.

Parent or Guradian Signature \_\_\_\_\_

Date \_\_\_\_\_

Revised 6/04