

# ADULT - HEALTH HISTORY FORM - ADULT

## ONLY FOR EVENTS LESS THAN 72 HOURS

### CENTRAL NEW JERSEY COUNCIL BSA

***PLEASE PRINT NEATLY AND USE INK  
TO BE FILLED OUT BY ALL ADULTS***

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ CURRENT AGE \_\_\_\_\_

NAME OF EMERGENCY CONTACT PERSON \_\_\_\_\_

EMERGENCY CONTACT'S AREA CODE + TELEPHONE \_\_\_\_\_

YOUR HOME ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

CHECK ALL ITEMS THAT APPLY, PAST OR PRESENT, TO YOUR HEALTH HISTORY. EXPLAIN ANY "YES" ANSWERS.  
ALLERGIES: FOOD, MEDICINES, INSECTS, PLANTS YES \_\_\_ NO \_\_\_ EXPLAIN:

\_\_\_\_\_

GENERAL INFORMATION:

	YES	NO		YES	NO		YES	NO		YES	NO
ASTHMA			CONVULSIONS/ SEIZURES			HEART TROUBLE			HIGH BLOOD PRESSURE		
CANCER			DIABETES			HEMOPHILIA			KIDNEY DISEASE		

LIST ANY MEDICATIONS TO BE TAKEN AT CAMP:

\_\_\_\_\_

LIST ANY PHYSICAL OR BEHAVIORAL CONDITIONS THAT MAY EFFECT OR LIMIT FULL PARTICIPATION IN SWIMMING,  
BACKPACKING, HIKING LONG DISTANCES, OR PLAYING STRENUOUS PHYSICAL GAMES:

\_\_\_\_\_

LIST EQUIPMENT NEEDED SUCH AS WHEELCHAIR, BRACES, GLASSES, CONTACT LENSES, ETC.

\_\_\_\_\_

IMMUNIZATIONS (GIVE YEAR OF LAST INOCULATION OR DISEASE):

TETANUS TOXOID \_\_\_\_\_ PERTUSSIS \_\_\_\_\_ MUMPS \_\_\_\_\_ POLIO \_\_\_\_\_

DIPHTHERIA \_\_\_\_\_ MEASLES \_\_\_\_\_ RUBELLA \_\_\_\_\_

NAME OF PERSONAL PHYSICIAN \_\_\_\_\_

PHYSICIAN TELEPHONE NO. \_\_\_\_\_

PERSONAL HEALTH/ACCIDENT INSURANCE CARRIER \_\_\_\_\_

POLICY NO. \_\_\_\_\_

TREATMENT AUTHORIZATION:

THIS HEALTH HISTORY IS CORRECT AS FAR AS I KNOW. IN THE EVENT OF ILLNESS OR ACCIDENT IN THE COURSE OF A BOY SCOUT ACTIVITY, I REQUEST THAT MEASURES BE INSTITUTED WITHOUT DELAY AS THE JUDGMENT OF MEDICAL PERSONNEL DICTATES.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_