

Arrowman Emergency Information and Treatment Authorization

Picture of Arrowman Here	MEDICAL ALERT: Activity Restrictions: Other Important Information:	HEALTH HISTORY Contact Lenses_____ Asthma_____ Allergy_____ To:_____ Special Diet_____ _____ Special Medication_____ _____
-----------------------------------	--	--

Name_____	District_____
Address_____	Troop_____
City, State_____	Zip_____
Date of Birth_____	Home Phone (____)_____
Physician_____	Phys Phone (____)_____
Health Insurance_____	Policy/ID No._____

MEDICAL HISTORY			
Is there disease of or past or present history of:			
	NO	YES	Year
Serious Illness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Serious Injury	<input type="checkbox"/>	<input type="checkbox"/>	_____
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Deformity	<input type="checkbox"/>	<input type="checkbox"/>	_____
Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin/Glands	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ears/Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nose/Sinus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Teeth/Tonsils	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dentures/Bridge	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chest/Lungs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart	<input type="checkbox"/>	<input type="checkbox"/>	_____
Murmur	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stomach/Bowels	<input type="checkbox"/>	<input type="checkbox"/>	_____
Appendicitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidneys/Urine	<input type="checkbox"/>	<input type="checkbox"/>	_____
Albama	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sugar/Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Infection	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bed-wetting	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hernia/Rupture	<input type="checkbox"/>	<input type="checkbox"/>	_____
Back/Limbs/Joints	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sleepwalking	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nervous Condition	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other (Explain)	<input type="checkbox"/>	<input type="checkbox"/>	_____

IN CASE OF EMERGENCY NOTIFY PARENTS OR GUARDIAN

Name _____	
Home Phone (____)_____	F Work (____)_____
M Work (____)_____	Other_____
Alternate Name _____	
Home Phone (____)_____	Work (____)_____

IMMUNIZATIONS		VACCINATIONS		
	Year Last Given	Vaccination	Disease	
Tetanus	_____	Measles	<input type="checkbox"/>	<input type="checkbox"/>
Diphtheria	_____	Mumps	<input type="checkbox"/>	<input type="checkbox"/>
Polio	_____	Rubella	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	Pertussis	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>

Parent Authorization and Emergency Consent

The above health history information is correct and complete so far as I/we know and is based upon that of a licensed physician. The above minor has permission to engage in all activities as noted until revoked by the undersigned. I/We certify that the above minor is physically fit. I/We know of no reason why he should not participate in any activity except as noted above.

I/We, the undersigned, parent(s)/guardian(s) of the above minor, do hereby authorize the adult leader(s) in charge as agent(s) for the undersigned to consent to any x-ray examination, anesthetic, medical surgical diagnosis or treatment and hospital care which is deemed advisable by, and is rendered under the general or special supervision of any physician or surgeon, licensed under the provisions of the Medical Practice Act on the medical staff of any accredited hospital, whether such diagnosis or treatment is rendered at the advice of said physician or at the said hospital. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required but is given to provide authority and payer on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician, in the exercise of his best judgment, may deem advisable. This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California.

Dated _____ Signature _____ Signature _____

Witness _____ Witness _____