KÜLFÖLDI MAGYAR CSERKÉSZSZÖVETSÉG

Hungarian Scout Troops 8& 49 – Los Angeles
3705 Woodlawn Ave., Los Angeles CA 90011

HEALTH FORM
>>> strictly confidential <<<

PERSONAL INFORMATION

NAME: _____ DATE OF BIRTH: ___/___/___ AGE: _____
(LAST) (FIRST) (MI) YY/MM/DD

SEX: Female ❑ Male ❑ Height: ____'____" Weight: _____ lbs
HOME ADDRESS: _____ Apt. _____
CITY: _____ STATE: ____ ZIP: _____ HOME PHONE #: (____) _____

IN CASE OF EMERGENCY CONTACT:

NAME OF CONTACT: _____ RELATIONSHIP:_____
HOME #: (___)_____ WORK #: (___)_____ CELL/PAGE #: (___)_____
STREET: _____ CITY: _____ STATE: ____ ZIP: _____

OR

NAME OF CONTACT: _____ RELATIONSHIP: _____
HOME #: (___)_____ WORK #: (___)_____ CELL/PAGE #: (___)_____
STREET: _____ CITY: _____ STATE: ____ ZIP: _____

HEALTH INSURANCE

HEALTH INSURANCE #: _____ INSURANCE COMPANY: _____
NAME OF POLICY HOLDER: _____ DATE OF LAST MEDICAL EXAM WAS: __/__/__
YY/MM/DD
DOCTOR'S NAME: _____ PHONE#: (___)_____
ARE YOU CURRENTLY BEING TREATED FOR ANYTHING ? NO ❑ YES ❑··
IF YES FOR WHAT ? _____

MEDICATIONS / ALLERGIES

MEDICATIONS BEING TAKEN AT PRESENT TIME (name, daily dosage, route eg. by mouth, for what condition):
_____

DO YOU HAVE KNOWN ALLERGIES ? ❑ NO ❑ YES

	ALLERGIC TO:	REACTION:
INSECTS /	_____	_____
ANIMALS	_____	_____
DRUGS	_____	_____
	_____	_____
PLANTS	_____	_____
	_____	_____
FOODS	_____	_____
	_____	_____
OTHER	_____	_____

(Revised, 2001)

PLEASE CONTINUE ON OTHER SIDE => => =>

PAST MEDICAL HISTORY

DO YOU SUFFER FROM	NO	YES	EXPLAIN
INFECTIOUS DISEASES (TUBERCULOSIS, HIV, ETC.)	❑	❑	
HEART CONDITIONS (CONGESTIVE HEART FAILURE, ANGINA, ETC.)	❑	❑	
BREATHING PROBLEMS (ASTHMA, BRONCHITIS, EMPHYSEMA, ETC.)	❑	❑	
BLOOD DISORDER PROBLEMS (CLOTS, STROKE, ANEMIA, ETC.)	❑	❑	
NERVOUS SYSTEM DISORDERS (SEIZURES, FAINTING, ETC.)	❑	❑	
MENTAL DISORDERS (SCHIZOPHRENIA, DEPRESSION, ETC.)	❑	❑	
KIDNEY PROBLEMS (KIDNEY DISEASE, URINARY TRACT INFECTION, ETC.)	❑	❑	
DIGESTIVE PROBLEMS (ULCERS, CONSTIPATION, IRRITABLE BOWEL, ETC.)	❑	❑	
HORMONAL PROBLEMS (DIABETES, THYROID, ETC.)	❑	❑	
ARE YOU PREGNANT (FEMALES 11 TO PREMENOPAUSAL)	❑	❑	

IF YES, APPROX. DATE OF CONCEPTION: ___/___/___ (YY/MM/DD) ESTIMATED DATE OF DELIVERY ___/___/___ (YY/MM/DD)

PLEASE GIVE APPROX. DATES IF APPLICABLE:

	YY/MM/DD		YY/MM/DD
EAR INFECTION	___/___/___	RHEUMATIC FEVER	___/___/___
CONVULSIONS	___/___/___	CHICKEN POX	___/___/___
MEASLES	___/___/___	GERMAN MEASLES	___/___/___
MUMPS	___/___/___	OTHER-DESCRIBE_____	___/___/___

PAST MEDICAL HISTORY

PLEASE NOTE THAT IT IS PROHIBITED TO ATTEND CAMP WITHOUT PROPER IMMUNIZATION, THEREFORE WITHOUT THIS PORTION BEING PROPERLA COMPLETED CAMPERS **CAN NOT** ATTEND CAMP.

	YY/MM/DD		BY/MM/DD
TETANUS	___/___/___	MEASLES	___/___/___
DIPTHERIA	___/___/___	MUMPS	___/___/___
POLIO	___/___/___	RUBELLA	___/___/___
HEPATITIS B VACCINE	___/___/___		

CONSENT TO MEDICAL TREATMENT

To the best of my knowledge, (I am) (the above named applicant _____ is) in good health and do / does not suffer from any physical, mental or emotional problems. In case of a medical emergency, permission is hereby given to the camp first aid staff, physician or health care facility designated by the Camp Director to hospitalize, secure proper treatment, order injections, anesthesia or surgery for me / the above named person.
I release the Hungarian Scout Association, its leaders, helpers and associates, as well as its participants and agents from all liabilities and damages incurred by me / my child while participating in all the various scouting activities, or from any liability which may result from medical services pursuant to this waiver.

DATE: ___/___/___ (YY/MM/DD) PRINTED NAME: _____ SIGNATURE: _____ RELATIONSHIP:_____