

Troop 191 Medical Form
Supplement/Summary 2014

Scout's Name: _____ Scout's DOB: _____

Age: _____ Weight: _____ Does your child have any allergies to medications: ___ Yes ___ No

If Yes, please explain: _____

<i>Allergy, Condition, Issue</i>	<i>Describe what happens to your child when an issue occurs, be specific. What medication is given.</i>

Scout's Name: _____ Scout's DOB: _____

<i>Allergy, Condition, Issue</i>	<i>Describe what happens to your child when an issue occurs, be specific. What medication is given.</i>

_____ I wish to be contacted EVERY TIME my child has a medical issue at the Troops Campsite and Is sent to the Infirmary (excluding daily medication runs when at camp).

_____ I wish to be contacted ONLY when there is an EMERGENCY with my child (excluding daily Medication runs when at camp).

First Contact No.: _____ Parent's Name: _____

Second Contact No.: _____ Parent's Name: _____

Third Contact No.: _____ Parent's Name: _____

I acknowledge and confirm that all of the information above is accurate and correct, sign below:

Mother: _____ Father: _____

Date: _____ Date: _____