

# SCOUT HEALTH HISTORY PERMISSION TO TREAT

Scout's Full Name: \_\_\_\_\_

Male \_\_\_\_\_ Female \_\_\_\_\_ Date of Birth \_\_\_\_\_

Present Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Date: \_\_\_\_\_

My child has the following diagnosed medical condition (s): \_\_\_\_\_

\_\_\_\_\_

My child takes the following medications (prescription or not) on a regular basis:

\_\_\_\_\_

My child has the following known allergies: \_\_\_\_\_

Please provide the following information about your family's Health Care insurance (Please attach a copy of your insurance card):

Company Name: \_\_\_\_\_

Policy Owner: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Father's Daytime Phone: \_\_\_\_\_ Time at this phone: \_\_\_\_\_

Father's Night Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Mother's Daytime Phone: \_\_\_\_\_ Time at this phone: \_\_\_\_\_

Mother's Night Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

If an emergency medical situation arises, and neither parent is available by phone, name and phone number of another contact person:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

I authorize the adult leadership of Boy Scout Troop 987 to seek emergency medical treatment for my child.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_