

**HEALTH AND MEDICAL STATEMENT  
TROOP 97 BSA**

Name of Scout _____									
Health/Accident Insurance Company _____	Policy Number _____								
My son/ward has or is subject to (check if yes): <input type="checkbox"/> Asthma <span style="margin-left: 200px;"><input type="checkbox"/> Diabetes</span> <input type="checkbox"/> Fainting spells <span style="margin-left: 150px;"><input type="checkbox"/> Heart trouble</span> <input type="checkbox"/> Convulsions <span style="margin-left: 150px;"><input type="checkbox"/> Bleeding disorders</span> <input type="checkbox"/> Allergy to any medication, food, plant, animal, or insect toxin <input type="checkbox"/> Any condition that may require special care, medication, or diet <input type="checkbox"/> None of the above									
Explain _____									
My son/ward has difficulty with (check if yes): <input type="checkbox"/> Eyes, ears, nose, throat <span style="margin-left: 150px;"><input type="checkbox"/> Lungs</span> <input type="checkbox"/> Digestion <span style="margin-left: 150px;"><input type="checkbox"/> Sleep walking</span> <input type="checkbox"/> Bed-wetting									
Any condition now requiring regular medication? _____									
Name of medication(s) _____									
Any restriction of activity for medical reasons? Explain _____									
Immunizations & Date of Last Inoculation: <table style="width: 100%; border: none;"><tr><td style="width: 50%;">Tetanus toxoid _____</td><td style="width: 50%;">Diphtheria _____</td></tr><tr><td>Polio _____</td><td>Measles _____</td></tr><tr><td>Mumps _____</td><td>Rubella _____</td></tr><tr><td>Pertussis _____</td><td></td></tr></table>		Tetanus toxoid _____	Diphtheria _____	Polio _____	Measles _____	Mumps _____	Rubella _____	Pertussis _____	
Tetanus toxoid _____	Diphtheria _____								
Polio _____	Measles _____								
Mumps _____	Rubella _____								
Pertussis _____									
Signature of Parent or Guardian _____	Date Signed _____								