

**BSA TROOP #347**  
**TROOP HEALTH FORM AND PARENTAL RELEASE**

**Required Contact Information**

Scout's Name: \_\_\_\_\_ Age: \_\_\_\_\_

Address \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**✚ IN CASE OF EMERGENCY NOTIFY:**

Name: \_\_\_\_\_ Relationship: Parent \_\_\_\_\_ Guardian \_\_\_\_\_ Other \_\_\_\_\_

Home Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Business Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Other Instructions: \_\_\_\_\_

**Required Health Information**

HAVE OR SUBJECT TO (check all that apply):

\_\_\_\_\_ Asthma      \_\_\_\_\_ Fainting      \_\_\_\_\_ Convulsions      \_\_\_\_\_ Swimming or sport restrictions

\_\_\_\_\_ Diabetes      \_\_\_\_\_ Heart trouble      \_\_\_\_\_ Allergy or allergic reaction to any medication, food, or other

\_\_\_\_\_ Other \_\_\_\_\_ Describe: \_\_\_\_\_

HAVE DIFFICULTY WITH (check all that apply):

\_\_\_\_\_ Eyes, ears, nose, throat      \_\_\_\_\_ Lungs      \_\_\_\_\_ Digestion

Any condition requiring regular medication? \_\_\_\_\_ Name of medication: \_\_\_\_\_

Any restriction of activity for medical reasons: \_\_\_\_\_ Explain: \_\_\_\_\_

**Required Parental Release**

I hereby consent with my son's participation in troop activities and outings and waive all claims against its leaders and/or against the officers, employees, agents, and representatives of the Erie Shores Council of the Boy Scouts of America in connection with any occurrence of accident or injury during the course of an activity or trip.

In the event my son should require immediate medical attention and/or treatment during the course of an activity or trip and after I cannot be contacted for the purpose of consenting to such treatment in a timely manner, I hereby give permission to any hospital, physician, and/or other appropriate health care provider selected by an adult leader of the activity or trip to undertake any form of medical treatment considered necessary or appropriate by such provider in such event.

Health insurance company: \_\_\_\_\_ Policy or group no.: \_\_\_\_\_

Parent/guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/guardian name (please print): \_\_\_\_\_