

### MEDICAL FORM

Scout's  
Name:

E Mail

Cell Phone

#### Parent's Information:

**PLEASE PRINT**

Name

Name

Address

Address

City

State

Zip

City

State

Zip

Home Phone

Cell Phone

Home Phone

Cell Phone

Work Phone

Ext

Work Phone

Ext

E Mail

E Mail

#### Emergency Contact:

#### Doctor's Information:

Name

Name of Practice

Address

Doctor's Name

City

State

Zip

City

State

Zip

Cell Phone

Home Phone

Office Phone

Office Fax

E Mail

E Mail

Relationship

Notes

#### DATE OF LAST TETANUS SHOT

Are there any allergies or medical conditions of which we should be aware?  None

What medication, if any, does your child take on a regular basis?  None

In case of emergency, my son \_\_\_\_\_ may receive necessary first aid treatment, receive medical treatment by a duly licensed physician and/or be admitted to a hospital in case of emergency. This remains in effect for the following calendar year \_\_\_\_\_ or the following dates:

Parent's Signature: **X** \_\_\_\_\_ Date \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Policy Number \_\_\_\_\_

Name of Insured \_\_\_\_\_

*Please keep this information updated with the troop.*