Arbuckle Area Council Boy Scouts of America
Medical Information/Informed Consent

Name:_____ **Telephone:**_____

Address:_____ _____ _____ _____
Street **City** **State** **Zip**

Birth date:_____ **Unit Organization:**_____

Name & Telephone of Personal Physician: _____ _____
Name **Telephone**

In Case of Emergency, Please Contact:_____ _____
Name **Telephone**

Special Diet Considerations: _____

_____

_____

List Known Allergies:

_____

_____

_____

List Required Medications:

_____

_____

_____

☐ **If you are allergic to bee stings, do you have a bee sting kit?** _____

☐ **Do you wear contact lenses?**_____ ☐ **Are you Pregnant?** _____

Have you had or do you now have (circle if yes):

Diabetes **Asthma** **Angina** **Epilepsy** **Chest Pains** **Drug Reactions**

High Blood Pressure **Heart Murmur** **Heart Attack** **(if yes, date _____)**

Have you ever had any serious disease or surgery? (If yes, explain & give date.): _____

_____

Do you have any other medical conditions that we should be aware of: _____

_____

I am not under the influence of any chemical substance including alcohol. Understanding that any physical activity involves a risk of injury, I understand that any physical activity involves a risk of injury, I understand that my participation in the arbuckle Area Council COPE Course is entirely voluntary. I release Arbuckle Area Council, its employees and staff, from any claims or liability arising out of my participation. This release does not, however, apply to any harm caused by negligence or willful misconduct of Arbuckle Area−Council, or its employees, or staff. ■

_____ _____ _____
Printed Name **Signature** **Date**

Parent/Guardian Signature _____ _____
Date

*** If the participant is under the age of 18, their parent / guardian must also sign.**