CATHOLIC COMMITTEE ON SCOUTING
RETREAT MEDICAL FORM

Name of Participant:	**Date of Birth:**
Name of family physician:	**Physician Phone # (include area code):**
Family medical/hospital insurance carrier:	**Policy or Group No.:**

Part I: Illnesses and Injuries (check those that apply)

- ❑ **Hypotension**
- ❑ **Ear Infection**
- ❑ **Bleeding/Clotting Disorders**
- ❑ **Hypertension**
- ❑ **Asthma**
- ❑ **Hypoglycemia**
- ❑ **Heart Defect/Disease**
- ❑ **Musculoskeletal Disorders**
- ❑ **Seizures**
- ❑ **Diabetes**
- ❑ **Other (specify):** ______________________

Date of last health examination: ______________________

Were any complicating medical problems noted in last health examination? ______________________

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Part II: Allergies (check those that apply and specify nature of allergic reactions)

- ❑ Animals ______________
- ❑ Hay fever ______________
- ❑ Pollen ______________
- ❑ Food ______________
- ❑ Medicines/drugs ______________
- ❑ Insect stings ______________
- ❑ Plants ______________
- ❑ Other (specify) ______________

Part III: Other health conditions (check those that apply)

- ❑ Bed Wetting
- ❑ Emotional disturbances
- ❑ Constipation
- ❑ Fainting
- ❑ Menstrual cramps
- ❑ Hearing impairment
- ❑ Motion sickness
- ❑ Sickle cell trait or disease
- ❑ Nosebleeds
- ❑ Special dietary regimen
- ❑ Sleep disturbances
- ❑ Wears glasses/contact lenses
- ❑ Other (specify) ______________________

Part IV: Immunization History

Immunization	Year Primary Series Completed	Year of Last Booster
D.T.P. Diphtheria Pertussis (whooping cough) Tetanus		
Td		
Measles		
Mumps		
Rubella		
(German measles)		
Oral Polio		
Hib		
Tuberculin Test (most recent)	Result	
Other		

Please explain any items that are checked. Also indicate any activities to be avoided or restricted.

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GIRL SCOUTS®

CATHOLIC COMMITTEE ON SCOUTING
RETREAT MEDICAL FORM

BOY SCOUTS

Name of Participant: ____________________________

Does applicant take medicine (prescription or over the counter) on a regular basis? (Check One)

Yes ☐ **No** ☐

If yes, please list in detail below:

Drug	Dosage	Route (Ex: oral, injection, etc)	Frequency

PARENTAL OR ADULT PARTICIPANT STATEMENT

To the best of my knowledge, the information on this form is accurate and complete. I request licensed health care practitioners to examine applicant, and to furnish requested information to other agencies as needed. I give my permission for full participation at this activity subject to limitations noted herein. In the event of illness or accident in the course of such activity, I request that measures be initiated without delay as judgment of medical personnel dictates.

Parent or guardian must sign if applicant is under 18:

Parent or guardian: ______________________________ **Date signed:** ________________

Applicant's signature: ______________________________ **Date signed:** ________________