Boy Scout Camp	**DeVos Family Venture Base Camp**
___ June 8 - 14 (Staff Week) ___ June 15 - 21 (Week 1) ___ June 22 – 28 (Week 2) ___ June 29 – July 5 (Week 3) ___ July 6 - 12 (Week 4) ___ July 13 – 19 (Week 5) ___ July 20 - 26 (Week 6) ___ July 27 - August 2 (Week 7) ___ August 3 - 9 (Week 8)	**TREK NAME** _____ **SESSION** _____
	Staff ___ Gerber Scout Camp ___ DeVos Family Venture Base Camp **TREK: 1** _____ **2** _____ **3** _____ **4** _____

2008 Health Form

Personal Health Form for Scout Under Age 18

Gerber Scout Camp / DeVos Family Venture Base Camp

Troop / Crew # _____

Weeks attending: _____

Please fill in the information requested- additional remarks are welcome.

Last Name	First Name	Middle Name	Date Of Birth	Age
Address (Number & Street)	City and State	County	Zip Code	Telephone (home)
Parent or Guardians First Name	Last Name	Middle Name	Telephone (work)	
Address (Number & Street)	City	County	State	Zip Code

If the person named above is not available in the event of an emergency, notify:

Name:_____ Telephone_____

Relationship_____

Name:_____ Telephone_____

Relationship_____

Health History

CONDITION	YES	NO	CONDITION	YES	NO
Asthma			Heart trouble		
Appendicitis attacks			Hemophilia		
Has the appendix been removed?			Kidney disorder		
Allergies (food, drugs-list details below)			Nervous Conditions		
Blood Pressure Problems			Nose or Sinus Problems		
Back. Limb or joint problems?			Out of breath easily		
Convulsions or seizures?			Skin or Gland problems		
Deformity (list below)			Sleep Walking		
Dentures			Stomach or Bowel problems		
Diabetes			Teeth or Tonsil problems		
Any exposure to contagious/infectious disease (i.e. TB, Hepatitis B)			Stinging Reaction Is a bee sting kit needed?		
Fainting			Tire easily		
Glasses/Contacts			Other		

Please use this space to explain any answers checked "yes" above:

Should activity be restricted because of any physical defect or illness?

□Yes □No *If "yes," please explain degree of restriction:*

Name of personal medical provider

;_____

Immunization History

Vaccination Dates	**Mo/Yr**	**Mo/Yr**	**Mo/Yr**
DPT	_____	_____	_____
TD (tetanus/diptheria)	_____	_____	_____
Tetanus	_____	_____	_____
Polio	_____	_____	_____
MMR	_____	_____	_____
or Measles	_____	_____	_____
or Mumps	_____	_____	_____
or Rubella	_____	_____	_____
Haemophilus influenza B	_____	_____	_____
Hepatitis B	_____	_____	_____
Varicella (Chicken Pox)	_____	_____	_____
Neg. TB Test or X-Ray	_____	_____	_____
BCG	_____	_____	_____

Medications needed Daily:

Medicine Name	Hours Given	Dosage

□ My child takes no medications on a routine basis.

STATE OF MICHIGAN REQUIRED AUTHORIZATIONS

The following information is required by the Michigan Department of Consumer and Industry Services pursuant to Public Act 116 and Administrative Rule 117.(2)(A).

Scouts Name_____

Pack/Troop_____

Authorization is granted for the release of the aforementioned individual to adult employees, staff, volunteers, and camp staff of the Gerald R. Ford Council, Boy Scouts of America. In addition to the parents or guardians signing this form, only those individuals listed below are authorized to remove the aforementioned from summer camp during their period of camping.

Name	Relationship

Parent or Gu**ardian Signature:**_____

Date:_____

Print_____

Parent or Gu**ardian Signature:**_____

Date:_____

Print_____

Camp information available at: www.bsagrfc.org

INSURANCE INFORMATION

□ My child is covered under a personal health insurance policy

PLEASE ATTACH A COPY OF THE INSURANCE CARD!

Policyholder's name:_____

Policyholder's birthdate:_____

Policyholder's employers:_____

Insurance company name:_____

Insurance company address:_____

Policy identification number:_____

Does your policy provide a prescription co-payment?_____

□ My child is NOT covered under a personal health insurance policy.

The following information is required by the Michigan Department of Consumer and Industry Services pursuant to Public Act 116 and Administrative Rule 127.1(1).

The health and history contained herein is correct as far as I know, and the person described has permission to engage in all prescribed activities, except as noted by me and/or the medical provider. In the event I cannot be reached in an emergency, I hereby give permission to the medical provider selected by a designated representative of the Boy Scouts of America to authorize emergency medical or surgical treatment, routine, non-surgical medical care, hospitalize, secure proper anesthesia, or to order injection(s) for my child. The person herein described is in good health, has all required immunizations current, and I assume the health responsibility for the individual.

***If for religious reasons you cannot sign this, contact the council for a legal waiver, which must be signed for attendance.**

Parent or Guardian Signature:_____Date:_____

Print_____

Parent or Guardian Signature:_____Date:_____

Print_____