SWARTZ CREEK AREA FIREFIGHTERS, INC.
EXPLORER POST 41
CLASS 1 PERSONAL HEALTH AND MEDICAL SUMMARY
BOY SCOUTS OF AMERICA - HEALTH AND SAFETY SERVICE

To be filled out by parent or guardian.*

Name of Explorer _____ Date of Birth _____ Age _____ Sex _____

Name of parent or guardian _____ Telephone _____

Home Address _____ City _____ Zip _____-_____

Business Address _____ City _____ Zip _____-_____

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

Name _____ Relationship _____ Telephone _____

Name _____ Relationship _____ Telephone _____

Name of personal physician _____ Telephone _____

Personal health/accident insurance carrier _____ Policy # _____

In case of emergency, I understand every effort will be made to contact me (if an adult, my spouse or next of kin). In the event I cannot be reached, I hereby give my permission to the physician selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for explorer listed above (for me, if an adult).

Date _____ Signature of parent/guardian or adult _____
Must be signed.

Please check medical information, past or present.

Asthma	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Leukemia	☐ Yes	☐ No
Allergies	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
Convulsions	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No	High BldPres	☐ Yes	☐ No

Explanations _____

Allergies: Food ☐ Yes ☐ No Plants ☐ Yes ☐ No
Medicines ☐ Yes ☐ No Insect Bites ☐ Yes ☐ No

Explanations _____

Any reason to restrict full activity including swimming, long hikes, backpacking, strenuous physical games and/or limited firefighting practices? ☐ Yes ☐ No

List any conditions limiting full participation (Physical or emotional): _____

Any special equipment such as orthopedic or handicap devices, glasses or contacts, dentures?
☐ Yes ☐ No What? _____

Explain any "yes" answers and give all information needed to provide as safe and as full participation as possible.

Immunizations:	Date of last Inoculation		Date of last Inoculation		Date of last Inoculation
Tetanus Toxoid	_____	Polio	_____	Mumps	_____
Diphtheria	_____	Pertussis	_____	Measles	_____
Rubella	_____				

My Daughter or Son may leave post activities only with the following persons (besides myself):
1. _____ 2. _____ 3. _____ 4. _____