

ERIE SHORES COUNCIL BOY SCOUTS OF AMERICA

C.O.P.E. Health/Understanding Form

Participant Name: _____ Age: _____ Course Date: _____

Address: _____
Number and Street, city zip

Home Phone: () _____

Emergency Medical Information for Participant

Check all items that apply to health history, past or present, and give explanation for all checks.

- | | |
|---|----------------------------|
| Allergies _____ | Asthma _____ |
| Food _____ | Convulsions/Seizures _____ |
| Medicine _____ | Diabetes _____ |
| Insects _____ | High Blood Pressure _____ |
| Other _____ | Kidney Problems _____ |
| Back Problems _____ | Head/Neck Problems _____ |
| Sprains _____ | Broken Bones _____ |
| Surgery _____ | Hernia _____ |
| Serious Injury _____ | Serious Illness _____ |
| Ears _____ | Eyes __, Glasses _____ |
| Contacts _____ | Nervous Condition _____ |
| Teeth __, Dentures _____, Bridge _____ | Mental Retardation _____ |
| Fainting _____ | Hemophilia _____ |
| Heart Condition _____, Murmur _____ Rheumatic Fever _____ | |
| Acrophobia / fear of heights _____ | |
| Claustrophobia (fear of narrow or closed spaces) _____ | |

Last Tetanus toxoid inoculation date: _____

List any medications to be taken, and schedule for them, while at camp:

List any physical or behavioral conditions that might prevent full participation in strenuous physical and mental activities: _____

Health/Accident Insurance Carrier: _____ Policy Number: _____

In case of an emergency, please contact: Name: _____

Address: _____

Business address and phone: _____

Home Phone: _____ Relationship: _____

If the person named above is not available, please contact:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Preferred Physician: _____ Phone: _____

Preferred Dentist: _____ Phone: _____

Emergency Medical Authorization

I understand that every effort will be made to contact my spouse or next of kin at the above number(s). In the event that they can not 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, injections, or medication for me.

Date: _____ Signature: _____

Statement of Understanding

I am aware in signing this statement of understanding for participation in C.O.P.E. that certain activities are physically, mentally and emotionally demanding. Physical fitness will increase my ability to participate. I shall consult with the Instructor before participation in any activity in which I feel my ability to participate may be limited or if I have questions about an activity. Some of the possible dangers that I may encounter while on the C.O.P.E. course include, but are not limited to, poison ivy, falling on the trail, cuts, bumps, bruises, insect bites, sprains, and fractures. Trained Instructors will supervise all activities to minimize risks. C.O.P.E. activities are held outside in all types of weather. I shall dress accordingly (rain gear, gloves, warm clothing). I recognize the necessity of following all safety procedures and instructions during activities on the C.O.P.E. course. I acknowledge the risks associated with this activity.

Date: _____ Signature of parent/guardian or adult participant: _____

Date: _____ Signature of youth: _____