

6TH ASEAN SCOUT JAMBOREE

HEALTH AND MEDICAL RECORD

HEALTH HISTORY

Have or subject to (check if yes):

<input type="checkbox"/> Fainting Spells	<input type="checkbox"/> Palpitation	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Headache	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Frequent Cough	<input type="checkbox"/> Easy Fatigue	<input type="checkbox"/> Frequent Fever
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Others: _____			

Have or subject to trouble with (check if yes):

<input type="checkbox"/> Eye, Ear, Nose, Throat	<input type="checkbox"/> Hernia
<input type="checkbox"/> Recurrent Diarrhea	<input type="checkbox"/> Heart
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Kidney
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Whooping Cough

Have had: (check if yes)

<input type="checkbox"/> Measles
<input type="checkbox"/> Mumps
<input type="checkbox"/> Chicken Pox

YEAR

Any condition now requiring regular medication? _____

Any restriction of activity for medical reasons? _____

Explain _____

IMMUNIZATION

Date of last inoculation

Smallpox	_____
Diphtheria	_____
Tetanus Toxoid	_____

Polio (Short or Oral)
Others

Date of last inoculation

If applicant is under 18 years of age: In the event of illness or injury occurring to my son/daughter during his attendance at the Jamboree, I hereby consent to advance to whatever medical or surgical diagnostic procedure or treatment is considered necessary in the best judgement of the attending physician and performed by or under the supervision of a member of the medical staff furnishing medical services. I understand that, in the event of a serious illness or injury, reasonable efforts to reach me will be attempted.

Signed: _____ Date: _____
Applicant

Approved by: _____
Parent or Guardian

MEDICAL EXAMINATIONS

TO THE PHYSICIAN: Your careful examination and written recommendation will encourage personal fitness and safe participation in strenuous outdoor activities. Review health history. If incomplete, please ask that this essential information be provided for your use.

PHYSICAL FINDINGS

Normal

Eyes
Vision
Ears
Nose
Throat
Teeth
Lungs
Heart
Blood Pressure
Abdomen
Hernia
Genitalia
Extremities
Posture (Spine)
Skin
Urinalysis
Emotional Stability

Abnormal

Explanation if abnormal

IMMUNIZATION (See history)

(Check One)

OK

Needed

Date Given

Smallpox	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diphtheria	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tetanus Toxoid	<input type="checkbox"/>	<input type="checkbox"/>	_____
Polio	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cholera / Dysentery / Typhoid	<input type="checkbox"/>	<input type="checkbox"/>	_____

I certify that I have reviewed the health history and examined this person and find him physically fit to participate in:

<input type="checkbox"/> Camping & Hiking	<input type="checkbox"/> Water Sports	<input type="checkbox"/> Competitive Sports
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Recommendations and/or restrictions (if none, so state): _____

Signed: _____ Signed: _____

Examinee

Physician and License No.