



Scouts Canada

Physical Fitness Certificate

NOTE: This form is to be filled out by the parent/guardian at the beginning of each Scouting year and kept by the leader. It is the parent's/guardian's responsibility to update the leader of any changes in the medical condition of their child/ward throughout the Scouting year. (This form should be filled out for adults as well.)

Surname: _____ Given Name: _____ Initial: _____ Date of Birth: _____ Age: _____ Male Female
 Address: _____ City: _____
 Province: _____ Postal Code: _____ Home Phone: _____
 Physician's Name: _____ Phone # _____ Scout Group Name: _____
 *Provincial Medical Plan: _____ Insurance Coverage Held: _____

Emergency Medical Information:

Does the applicant have any allergies? Yes No If yes, please indicate below.

- | | | | | |
|-----------------------------------|---------------------------------------|---------------------------------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Medicine | <input type="checkbox"/> Insect Bites | <input type="checkbox"/> Toxins | <input type="checkbox"/> Food | <input type="checkbox"/> Smoke |
| <input type="checkbox"/> Plants | <input type="checkbox"/> Animals | <input type="checkbox"/> Other | | |

Details: _____

Has had, please check (x)

- | | | | | |
|--|--|--|----------------------------------|---|
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Mumps | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Measles | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Heart condition | <input type="checkbox"/> Other | |

Is subject to any of the following, check (x) and give details:

- | | | | | |
|--|---|--------------------------------------|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Contact Lenses | <input type="checkbox"/> Headaches | <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Bleeding disorders |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Ear problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hernia | <input type="checkbox"/> Back problems |
| <input type="checkbox"/> Motion sickness | <input type="checkbox"/> Cramps | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Sleepwalking | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Other _____ | | | |

Details: _____

If female, has youth participant menstruated? Yes No
 If no, has she had menstruation explained to her? Yes No Pregnant?

Does the participant require special care, medication or diet? Yes No

Details: _____

Date of most recent physical examination (Month and Year): _____

Date of last tetanus shot (Month and Year): _____

Swimming abilities: Non Swimmer Swimmer (Highest Level Achieved): _____

Has it ever been necessary to restrict the applicant's activities for medical reasons? Yes No

Details: _____

Signed, Parent/Guardian: _____ Date: _____

Updated, Parent/Guardian: _____ Date: _____

Updated, Parent/Guardian: _____ Date: _____

*Voluntary in some provinces