

Fill Out and Mail To:



Order of the Arrow – BSA
 Southeast Louisiana Council
 P.O. Box 1146
 Metairie, La. 70004

**Please include \$33.00 to cover
 the cost of the Ordeal
 Make check payable to:
 Southeast Louisiana Council**

Name		Unit		District	
Address		City		State	Zip
Phone	Amount Enclosed	Adult <input type="checkbox"/>	Youth <input type="checkbox"/>	Birth Date	

Parents: Please fill out the Health History completely. Failure to do so will prevent your son from participating in the Ordeal.

Adult Candidates: Please fill out the Health History for yourself.

Health History				
Please Print				
Name		Address		
City		State	Zip	
Health/Accident Insurance Company		Policy Number		
Have or subject to (check if yes)				
<input type="checkbox"/> Asthma <input type="checkbox"/> Fainting Spells <input type="checkbox"/> Convulsions <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Trouble <input type="checkbox"/> Bleeding disorders		<input type="checkbox"/> None <input type="checkbox"/> Allergy to any medication, food, plant, animal, or insect toxin <input type="checkbox"/> Any condition that may require special care, medication, or diet		
Explain Details				
Have difficult with (check if yes):				
<input type="checkbox"/> Eyes, ears nose, throat <input type="checkbox"/> Digestion <input type="checkbox"/> Bed-wetting <input type="checkbox"/> Lungs <input type="checkbox"/> Sleepwalking				
Any condition now requiring regular medication? _____ Name of Medication: _____				
Any restriction of activity for medical reasons? _____ Explain: _____				
Immunizations	Date of last inoculation	Date of last inoculation	Date of last inoculation	Date of last inoculation
Tetanus toxoid _____	Polio _____	Mumps _____	Pertussis _____	
Diphtheria _____	Measles _____	Rubella _____		
Parent Authorization				
This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed activities, except as noted by me. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the adult leader in charge to hospitalize, secure proper anesthesia, or to order injection for my son.				
Signature: _____ Date: _____				
Parent or Guardian				
Home Telephone Number			Business Telephone Number	