



## 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

July 2002