



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: _____
 Physicians Name: _____ Scout Group Name: _____
 *Provincial Medical Plan Number: _____ 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"/> Scarlet Fever | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Other _____ | |

If 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"/> Pregnant | <input type="checkbox"/> Other _____ | | |

Details: _____

Has participant menstruated? ☐ Yes ☐ No If no, has she had menstruation explained to her? ☐ Yes ☐ No

Does the participant require special care, medication or diet?

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: _____