



SUMMER CAMP MEDICAL FORM INSTRUCTIONS

Accurate medical records for campers and staff are required by BSA standards and • æ^ Áæ . They are also critical to ensure timely, effective care should you or your Scout become sick or injured while at camp. All campers, adult leaders and staff **MUST** complete the BSA Annual Health and Medical Record form annually. Forms expire after 12 months.

Scouts, leaders, parents, and visitors WILL NOT PARTICIPATE in many camp activities including (but not limited to) swimming, boating, climbing, COPE, and sports, and may not remain in camp longer than 72 hours without a completed medical form.

Read the medical form carefully. The next page highlights areas that are commonly incomplete. All portions of the form must be completed for ALL summer camp programs.

Please take note of the following changes:

PART A:

This page contains an important risk advisory, informed consent, and release. Please read this advisory carefully. The participant and parents (if participant is under 18) must sign to acknowledge agreement with the information on this page.

This page also includes space to list adults who are authorized (or prohibited) to take this participant to/ from events.

PART B:

Part B contains the participant's contact and insurance information and generic health history. Page 2 of this section contains information about medication and allergies. Please complete these sections carefully and accurately. The parents and health care professional must sign to authorize all medication.

PART C:

Part C is the annual physical. This page should be completed and signed by the health care professional conducting the physical examination. Physicals are required within 12 months of an event lasting longer than 72 hours.

COMMON MISTAKES:

- Missing parent/guardian signature (Part A)
- Missing emergency contact information (Part B)
- Incomplete medication information (Part B)
- Missing medical insurance card (Part B)
- Missing immunization record (Part B)
- Missing physician signature (Part B & C)
- Physical exam more than 12 months ago (Part C)

NOTE: State regulations require that your complete immunization record be , !ã^ } Á } Á@ Á ^ããd form. Áã [| ^ Á [Á&@ { ^ } Á^ Á&&^ } ÁãE

MEDICAL FORMS ARE NOT RETURNED AT THE END OF CAMP. Always submit a **COPY** of your medical form. Keep the original for use at other Scouting activities.

PART A - Page 1

Part A: Informed Consent, Release Agreement, and Authorization

Full name: _____ High-adventure base participants:
Expedition/crew No.: _____
or staff position: _____

DOB: _____

Informed Consent, Release Agreement, and Authorization
I understand that, if any information was made previously available to me, I may not and/or decline the opportunity to participate in any event or activity if I am participating at Phoenix, Phoenix Training Center, or at any other location, including Florida Sea Base, or the National District/Region. I have also read and understand the supplemental program if those participants are not. The participant will not be allowed to participate in any high-adventure program if those participants are not. The participant will not be allowed to participate in any high-adventure program if those participants are not. The participant will not be allowed to participate in any high-adventure program if those participants are not.

Adults Authorized to Take to and from Events:
Name: _____ Signature: _____
Name: _____ Signature: _____

Adults NOT Authorized to Take Youth to and from Events:
Name: _____ Signature: _____
Name: _____ Signature: _____

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Participant and parents (if participant is under 18) must sign to acknowledge the informed consent and release on this page.

Adults authorized to, or prohibited from, taking a participant to/from an event.

PART B - Page 1

Part B: General Information/Health History

Full name: _____ High-adventure base participants:
Expedition/crew No.: _____
or staff position: _____

DOB: _____

Age: _____ Gender: _____ Height (inches): _____ Height (feet): _____

Address: _____

City: _____ State: _____ Zip: _____

Cell mobile: _____ Middle phone: _____ Home phone: _____

Country: _____

Health History
Please attach a photocopy of both sides of the insurance card. If you do not have medical insurance, enter "none" above.

In case of emergency, notify the person below:
Name: _____ Relationship: _____
Address: _____ Home phone: _____ Cell phone: _____
Alternate phone: _____

Yes	No	Condition	Equipment
<input type="checkbox"/>	<input type="checkbox"/>	Cholesterol	Last lipid percentage and date:
<input type="checkbox"/>	<input type="checkbox"/>	Hypertension (high blood pressure)	
<input type="checkbox"/>	<input type="checkbox"/>	Adult or congenital heart (heart/heart attack/heart pain/angina/heart murmur/heart valve disease, etc.) Last height or procedure (date of your event):	
<input type="checkbox"/>	<input type="checkbox"/>	Family history of heart disease or any other heart related heart or a family member before age 50:	
<input type="checkbox"/>	<input type="checkbox"/>	Stroke/TIA	
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	Last attack date:
<input type="checkbox"/>	<input type="checkbox"/>	Lung/Respiratory Disease	
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	
<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol problems	
<input type="checkbox"/>	<input type="checkbox"/>	Uncontrolled condition/episode of BPH (BPH)	
<input type="checkbox"/>	<input type="checkbox"/>	Head Injury/Concussion	
<input type="checkbox"/>	<input type="checkbox"/>	Allergic reactions	
<input type="checkbox"/>	<input type="checkbox"/>	Phyromedical/psychological or emotional difficulties	
<input type="checkbox"/>	<input type="checkbox"/>	Spinal/Neck/leg/arm/shoulder	
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal electrocardiogram (ECG)	
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal blood test (not diabetes)	
<input type="checkbox"/>	<input type="checkbox"/>	Smoking status and duration	
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol use	
<input type="checkbox"/>	<input type="checkbox"/>	Seizures	LAST SEIZURE DATE:
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal renal/kidney problems	
<input type="checkbox"/>	<input type="checkbox"/>	Dental issues	
<input type="checkbox"/>	<input type="checkbox"/>	Excessive fatigue	
<input type="checkbox"/>	<input type="checkbox"/>	Chronic or long-term respiratory conditions	CPAP: Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	List of surgeries and hospitalizations	Last surgery date:
<input type="checkbox"/>	<input type="checkbox"/>	List any other medical conditions not covered above	

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Include insurance information and attach a copy of the participant's insurance card.

PART B - Page 2

Part B: General Information/Health History

Full name: _____ High-adventure base participants:
Expedition/crew No.: _____
or staff position: _____

DOB: _____

Allergies/Medications

List all allergies currently used, including any over-the-counter medications.
 CHECK HERE IF NO MEDICATIONS ARE ROUTINELY TAKEN. IF ADDITIONAL SPACE IS NEEDED, PLEASE INDICATE ON A SEPARATE SHEET AND ATTACH.

Medication	Dose	Frequency	Reason

Immunization
The following immunizations are recommended by the CDC. Please indicate if you have received each of these immunizations and the date. If immunized, check (y) and provide the year.

Age	Yes	No	Year
Tetanus	<input type="checkbox"/>	<input type="checkbox"/>	
Polio	<input type="checkbox"/>	<input type="checkbox"/>	
Diphtheria	<input type="checkbox"/>	<input type="checkbox"/>	
Measles/Mumps/Rubella	<input type="checkbox"/>	<input type="checkbox"/>	
Hib	<input type="checkbox"/>	<input type="checkbox"/>	
Chicken-Pox	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	
Shingles	<input type="checkbox"/>	<input type="checkbox"/>	
HPV	<input type="checkbox"/>	<input type="checkbox"/>	
Other (e.g., TB)	<input type="checkbox"/>	<input type="checkbox"/>	

Parent and physician must sign to authorize medication.

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List all allergies, and medications taken here.

Parent and physician must sign to authorize medication.

PART C - Page 1

Part C: Pre-Participation Physical

This part must be completed by certified and licensed physicians (MD or DO).

Full name: _____ High-adventure base participants:
Expedition/crew No.: _____
or staff position: _____

DOB: _____

Examiner's Certification
I certify that I have reviewed the health history and examined this person and that no contraindications for participation in a scouting sequence. This participant meets all requirements for participation in a scouting sequence. For high-adventure participants, I have reviewed with them the required equipment.

Examiner's Signature: _____ Date: _____
Printer print name: _____
Address: _____
City: _____ State: _____ Zip code: _____
Other phone: _____

Height (inches)	Max. Weight	Height (inches)	Max. Weight	Height (inches)	Max. Weight	Height (inches)	Max. Weight
42	100	48	150	54	200	60	250
44	110	50	160	56	210	62	260
46	120	52	170	58	220	64	270
48	130	54	180	60	230	66	280
50	140	56	190	62	240	68	290
52	150	58	200	64	250	70	300
54	160	60	210	66	260	72	310
56	170	62	220	68	270	74	320

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Health care professional completes this page.

Health care professional must sign here.