

PERSONAL HEALTH AND MEDICAL RECORD FORM – CLASS 3

I. Identification Age: _____ Sex _____ Date of birth*
 Name: _____
 Last Name First Name Initial Mo. Day Year
 Address _____
 City _____ State _____ Zip _____
IN AN EMERGENCY NOTIFY:
 Parent: _____ Home: () _____-_____
 Address: _____ Work: () _____-_____
 _____ Cell: () _____-_____
Other Emergency Contact:
 Name: _____ Home: () _____-_____
 Work: () _____-_____
 Cell: () _____-_____

BOY SCOUTS OF AMERICA

All class 3 activities require a health examination within the past 12 months by a licensed health-care practitioner.* This includes youth and adult members participating in high-adventure activities, athletic competition and world jamborees. Annually, this form is to be used by adults over 40 for all activities requiring a physical examination and applies to all Woodbadge participants/staff regardless of age.

II. EMERGENCY MEDICAL INFORMATION

Has or is subject to (check and give details, use back if needed):
 Allergy to a medicine, food**, plant, animal or insect toxin
 Any condition that may require special care, medication or diet
 ADHD (Attention Deficit Hyperactive Disorder)
 Asthma Convulsion Heart trouble Contact lenses
 Diabetes** Fainting spells Bleeding disorders Dentures
 Explain: _____

III. PARENTAL STATEMENT

Has it ever been necessary to restrict applicant's activities for medical reasons? Yes No Does applicant take medicine regularly or have special care? No Yes

If yes, explain: _____
 I have reviewed and to the best of my knowledge, the information in sections I, II, III, IV, V, VI, VII, VIII and IX is accurate and complete. I request a licensed health-care practitioner to examine applicant, to give needed immunization and to furnish requested information to other agencies as needed. I give my permission for all participation in BSA programs, subject to limitations noted herein. In the event of illness or accident in the course of such activity, I request that measures be instituted without delay as judgment of medical personnel dictates.

Parent or guardian _____
 (must sign if applicant is 18 or younger)
 Applicant's signature _____
 Date Signed: _____

IV. IMMUNIZATIONS

If disease, put "D" and year, Last date given
 Tetanus _____
 Diphtheria _____
 Pertussis _____
 Measles _____
 Mumps _____
 Rubella _____
 Polio _____
 Chicken Pox _____
 Haemophilus influenza type b _____
 Hepatitis b _____

Religious Preference

V. LICENSED HEALTH-CARE PRACTITIONER'S EVALUATION & ADVICE

Approved for participation in:
 Hiking and camping Water activities
 Competitive sports All activities
 Specify exceptions _____
 Recommendations (explain any restrictions or limitations):
 Health Care Providers Name _____
 Phone _____ Date _____
 Signed _____
 Licensed health-care practitioner

Examinations conducted by a licensed health-care practitioner other than physicians will be recognized for BSA purposes in those states where such practitioners may perform physical examinations within their legally prescribed scope of practice.

Name: _____
Unit: Troop 166
Note: Keep original form for your personal record. Make reproductions for agency use. Be sure information and signatures are legible on reproduced copies. The upper section may be reproduced and carried with you for emergency identification and care.

MEDICAL HISTORY

Parent (or applicant if 18 or older): Fill in sections I, II, III, IV and VI before seeing a licensed health-care practitioner. Check immunizations to be given at this time. Be sure to include any emergency information and restrictions or special care that should be observed. Especially be sure to record an injury, illnesses, surgery or significant changes in condition of health of applicant since last complete examination.

Date of most recent complete physical examination (month & year) _____ 20____
 Are you aware of any current health problems? Yes No
 Now under medical care or taking medications? Yes No
 Has there been any surgery, injury, illness or change
 In health status since last complete physical examination? Yes No
 Give dates and full details below for any "yes" answers.

IS THERE DISEASE OF (OR PAST OR RESENT HISTORY OF):

	No	Yes	Date	Details
Serous illness	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Serious injury	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Deformity	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Skin, glands	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Ears, eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Nose, sinus	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Teeth, tonsils	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Dentures	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Bridge	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Chest, lungs	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Heart	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Murmur	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Stomach, bowels	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Appendicitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Kidneys or urine	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Albumin	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Sugar	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Infection	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Bed-wetting	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Menstrual problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hernia (rupture)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Back, limbs, joints	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Sleepwalking	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Nervous condition	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Other (explain)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

VII. HEALTH EXAMINATION

Licensed Health-Care Practitioner:
The applicant will be participating in a strenuous activity that will include one or more of the following: athletic competition, adventure challenge or wilderness expedition (afloat or afloat) that may include high altitude, extreme weather conditions, cold water, exposure, fatigue, and/or remote conditions where readily available medical care cannot be assured.
 Please insist applicant furnish complete medical history (VI) before exam.
 Review immunizations: for youth (18 or younger) tetanus and diphtheria toxoids, measles, mumps and rubella vaccines and trivalent oral polio vaccine are required; youths and adults must have tetanus booster within ten years. A measles booster is recommended at age 12.
 After completing section VII. Summarize any restrictions and/or recommendations in sections II and V above, review section VIII, list medication(s) and strike any medication not approved for use and sign.

Date _____ VISION HEARING:
 Ht. _____ Wt. _____ Normal _____ Normal _____
 B.P. _____/_____ Glasses _____ Abnormal _____
 Pulse _____ Contacts _____

Check box if normal; circle if abnormal and give details below:
 Growth, Teeth, tonsils Genitourinary
 Skin, glands, hair Respiratory Skeletomuscular
 Head, neck, thyroid Cardiovascular Neuropsychiatry
 Eyes, ears, nose Abdomen, hernia, Other (specify)

Comments _____

LABORATORY: Urinalysis (dip stick) Albumin _____ Sugar _____

For Those Attending Philmont or National High-Adventure Bases:

* The minimum age for all participation is 13 by January 1 of the year of participation. No exceptions.
 ** Trail food is by necessity a high-carbohydrate, high-calorie diet. It is high in wheat, milk products, sugar, corn syrup and artificial coloring/flavoring. Dinner meals contain meat. If these food products cause a problem in your diet, you need to bring appropriate substitutions with you and so advise base personnel.

Note: Licensed health-care practitioners representing the high-adventure bases reserve the right to deny access to the trails or other program activity on the basis of a medical evaluation at the base after arrival.

SUMMER CAMP MEDICAL FORM

TRCBSA

rev 10/28/08

<p>VIII. HEALTH-CARE PRACTITIONER MEDICATION ORDERS</p> <p>Applicant takes the following medication(s) as follows:</p> <p>Med. #1 _____ Dosage _____ Times _____</p> <p>Med. #2 _____ Dosage _____ Times _____</p> <p>Note additional medications or to give more detailed information use notes section below or attach additional page(s). Identify any medication(s) taken during the school year that applicant does/may not take during the summer.</p> <p>The camp Medical Officer may give the following over the counter medications as per label instructions based on age and weight:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"> <ul style="list-style-type: none"> •Diphenhydramine USP •Chlortremeton •Ivarest Topical •Calamine Topical •Guiatuss (Robitussin) •Novafed •Actifed •Acetominophen </td> <td style="width: 50%; border: none;"> <ul style="list-style-type: none"> •Topical Tinactin Liquid or powder •Chloraseptic Gargle (or equivalent) •Caladryl Topical •Topical Hydrocortisone 0.5% cream •Keopectate •Sudafed •Ibuprophen •Other _____ </td> </tr> </table> <p>Strike out any medication that should not be given</p>	<ul style="list-style-type: none"> •Diphenhydramine USP •Chlortremeton •Ivarest Topical •Calamine Topical •Guiatuss (Robitussin) •Novafed •Actifed •Acetominophen 	<ul style="list-style-type: none"> •Topical Tinactin Liquid or powder •Chloraseptic Gargle (or equivalent) •Caladryl Topical •Topical Hydrocortisone 0.5% cream •Keopectate •Sudafed •Ibuprophen •Other _____ 	<p>IX. GENERAL INFORMATION</p> <p>This Personal Health & Medical Record is treated as confidential. Medical information may be shared with necessary staff members to insure the health and safety of the applicant.</p> <p>All prescribed medication must be in the original container and properly labeled by a physician or pharmacist. Insure enough medication is provided to for the length of the applicants stay at camp. All medication left at camp will be destroyed within one week after applicant leaves camp.</p> <p>Additional Notes:</p>
<ul style="list-style-type: none"> •Diphenhydramine USP •Chlortremeton •Ivarest Topical •Calamine Topical •Guiatuss (Robitussin) •Novafed •Actifed •Acetominophen 	<ul style="list-style-type: none"> •Topical Tinactin Liquid or powder •Chloraseptic Gargle (or equivalent) •Caladryl Topical •Topical Hydrocortisone 0.5% cream •Keopectate •Sudafed •Ibuprophen •Other _____ 		

FOR CAMP USE ONLY

MEDICAL RE-CHECK	
Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No _____	Restrictions <input type="checkbox"/> Yes <input type="checkbox"/> No _____
Medications <input type="checkbox"/> Yes <input type="checkbox"/> No _____	Medical Alert <input type="checkbox"/> Yes <input type="checkbox"/> No _____
Feels Today _____	New Condition _____
Emergency contact information verified _____	
Notes:	

MEDICAL RE-CHECK	
Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No _____	Restrictions <input type="checkbox"/> Yes <input type="checkbox"/> No _____
Medications <input type="checkbox"/> Yes <input type="checkbox"/> No _____	Medical Alert <input type="checkbox"/> Yes <input type="checkbox"/> No _____
Feels Today _____	New Condition _____
Emergency contact information verified _____	
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Medications <input type="checkbox"/> Yes <input type="checkbox"/> No _____	Medical Alert <input type="checkbox"/> Yes <input type="checkbox"/> No _____
Feels Today _____	New Condition _____
Emergency contact information verified _____	
Notes:	