



201) 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.

The 2014 form has changed. 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, the undersigned, hereby give my consent and authorization to the Florida State University (FSU) to use my name and likeness in any and all promotional materials, including but not limited to, brochures, newsletters, magazines, and other printed or electronic materials, for the purpose of promoting the activities of the FSU, and to allow FSU to use my name and likeness in any and all promotional materials, including but not limited to, brochures, newsletters, magazines, and other printed or electronic materials, for the purpose of promoting the activities of the FSU.

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

Participant signature: _____ Date: _____

Parent/guardian signature for youth: _____ Date: _____

Adults Authorized to Take to and from Events:

Name: _____ Signature: _____

Adults NOT Authorized to Take Youth to and from Events:

Name: _____ Signature: _____

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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 number: _____ Mobile phone: _____ Land line: _____

Country: _____

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

Health/Insurance Company: _____ Policy No.: _____

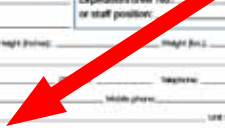
Health History

Do you currently have or have you ever been treated for any of the following?

Yes	No	Condition	Equinox
<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 condition (attach most recent echocardiogram report to this form)	
<input type="checkbox"/>	<input type="checkbox"/>	Family history of heart disease or any sudden heart death of 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"/>	DM/MS	
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes/Pre-diabetes problems	
<input type="checkbox"/>	<input type="checkbox"/>	Major medical condition (stroke or other issue)	
<input type="checkbox"/>	<input type="checkbox"/>	Head Injury/Concussion	
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Abuse	
<input type="checkbox"/>	<input type="checkbox"/>	Pharmaceutical/psychological or emotional condition	
<input type="checkbox"/>	<input type="checkbox"/>	Spinal/Neck/leg/arm condition	
<input type="checkbox"/>	<input type="checkbox"/>	Abuse (alcohol/drugs/sexual abuse)	
<input type="checkbox"/>	<input type="checkbox"/>	Smoking (past and present)	
<input type="checkbox"/>	<input type="checkbox"/>	Other Disease	
<input type="checkbox"/>	<input type="checkbox"/>	Seizures	LAST SEIZURE DATE:
<input type="checkbox"/>	<input type="checkbox"/>	Appetite/Intestinal/Digestive problems	
<input type="checkbox"/>	<input type="checkbox"/>	Organic Disease	
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Fatigue	
<input type="checkbox"/>	<input type="checkbox"/>	Chronic/long-term respiratory condition	CPAP: Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	List all 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.



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 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.

Yes	No	Allergies or Reactions	Hydrate	English	English
<input type="checkbox"/>	<input type="checkbox"/>	Medication			
<input type="checkbox"/>	<input type="checkbox"/>	Food			

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

Yes	No	Most Diseases	Documentation
<input type="checkbox"/>	<input type="checkbox"/>	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)	

Parent and physician must sign to authorize medication.

Participant signature: _____ Date: _____

Parent/guardian signature: _____ Date: _____

Physician signature: _____ Date: _____

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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 exist. This participant meets the minimum requirements for participation in the following activities:

Activity	Yes	No
High-altitude	<input type="checkbox"/>	<input type="checkbox"/>
Technical climbing	<input type="checkbox"/>	<input type="checkbox"/>
Rock climbing	<input type="checkbox"/>	<input type="checkbox"/>
Water activities	<input type="checkbox"/>	<input type="checkbox"/>
Swimming	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>

Health care professional must sign here.

Physician signature: _____ Date: _____

Physician name: _____

Address: _____

City: _____ State: _____ Zip: _____

Other phone: _____

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Health care professional completes this page.

Health care professional must sign here.

Part A: Informed Consent, Release Agreement, and Authorization

Full name: _____
DOB: _____

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

Informed Consent, Release Agreement, and Authorization

I understand that participation in Scouting activities involves the risk of personal injury, including death, due to the physical, mental, and emotional challenges in the activities offered. Information about those activities may be obtained from the venue, activity coordinators, or your local council. I also understand that participation in these activities is entirely voluntary and requires participants to follow instructions and abide by all applicable rules and the standards of conduct.

In case of an emergency involving me or my child, I understand that efforts will be made to contact the individual listed as the emergency contact person by the medical provider and/or adult leader. In the event that this person cannot be reached, permission is hereby given to the medical provider selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for me or my child. Medical providers are authorized to disclose protected health information to the adult in charge, camp medical staff, camp management, and/or any physician or health-care provider involved in providing medical care to the participant. Protected Health Information/Confidential Health Information (PHI/CHI) under the Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. §§160.103, 164.501, etc. seq., as amended from time to time, includes examination findings, test results, and treatment provided for purposes of medical evaluation of the participant, follow-up and communication with the participant's parents or guardian, and/or determination of the participant's ability to continue in the program activities.

(If applicable) I have carefully considered the risk involved and hereby give my informed consent for my child to participate in all activities offered in the program. I further authorize the sharing of the information on this form with any BSA volunteers or professionals who need to know of medical conditions that may require special consideration in conducting Scouting activities.

With appreciation of the dangers and risks associated with programs and activities, on my own behalf and/or on behalf of my child, I hereby fully and completely release and waive any and all claims for personal injury, death, or loss that may arise against the Boy Scouts of America, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with any program or activity.

I also hereby assign and grant to the local council and the Boy Scouts of America, as well as their authorized representatives, the right and permission to use and publish the photographs/film/videotapes/electronic representations and/or sound recordings made of me or my child at all Scouting activities, and I hereby release the Boy Scouts of America, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with the activity from any and all liability from such use and publication. I further authorize the reproduction, sale, copyright, exhibit, broadcast, electronic storage, and/or distribution of said photographs/film/videotapes/electronic representations and/or sound recordings without limitation at the discretion of the BSA, and I specifically waive any right to any compensation I may have for any of the foregoing.



NOTE: Due to the nature of programs and activities, the Boy Scouts of America and local councils cannot continually monitor compliance of program participants or any limitations imposed upon them by parents or medical providers. However, so that leaders can be as familiar as possible with any limitations, list any restrictions imposed on a child participant in connection with programs or activities below.



List participant restrictions, if any: None

I understand that, if any information I/we have provided is found to be inaccurate, it may limit and/or eliminate the opportunity for participation in any event or activity. If I am participating at Philmont, Philmont Training Center, Northern Tier, Florida Sea Base, or the Summit Bechtel Reserve, I have also read and understand the supplemental risk advisories, including height and weight requirements and restrictions, and understand that the participant will not be allowed to participate in applicable high-adventure programs if those requirements are not met. The participant has permission to engage in all high-adventure activities described, except as specifically noted by me or the health-care provider. If the participant is under the age of 18, a parent or guardian's signature is required.

Participant's signature: _____ Date: _____

Parent/guardian signature for youth: _____ Date: _____

(If participant is under the age of 18)

Second parent/guardian signature for youth: _____ Date: _____

(If required; for example, California)

Complete this section for youth participants only:

Adults Authorized to Take to and From Events:

You must designate at least one adult. Please include a telephone number.

Name: _____ Name: _____

Telephone: _____ Telephone: _____

Adults NOT Authorized to Take Youth To and From Events:

Name: _____ Name: _____

Telephone: _____ Telephone: _____



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Part B: General Information/Health History

Full name: _____

DOB: _____

High-adventure base participants:

Expedition/crew No.: _____

or staff position: _____

Age: _____ Gender: _____ Height (inches): _____ Weight (lbs.): _____

Address: _____

City: _____ State: _____ ZIP code: _____ Telephone: _____

Unit leader: _____ Mobile phone: _____

Council Name/No.: _____ Unit No.: _____

Health/Accident Insurance Company: _____ Policy No.: _____



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: _____ Other phone: _____

Alternate contact name: _____ Alternate's phone: _____

Health History

Do you currently have or have you ever been treated for any of the following?

Yes	No	Condition	Explain
		Diabetes	Last HbA1c percentage and date:
		Hypertension (high blood pressure)	
		Adult or congenital heart disease/heart attack/chest pain (angina)/heart murmur/coronary artery disease. Any heart surgery or procedure. Explain all "yes" answers.	
		Family history of heart disease or any sudden heart-related death of a family member before age 50.	
		Stroke/TIA	
		Asthma	Last attack date:
		Lung/respiratory disease	
		COPD	
		Ear/eyes/nose/sinus problems	
		Muscular/skeletal condition/muscle or bone issues	
		Head injury/concussion	
		Altitude sickness	
		Psychiatric/psychological or emotional difficulties	
		Behavioral/neurological disorders	
		Blood disorders/sickle cell disease	
		Fainting spells and dizziness	
		Kidney disease	
		Seizures	Last seizure date:
		Abdominal/stomach/digestive problems	
		Thyroid disease	
		Excessive fatigue	
		Obstructive sleep apnea/sleep disorders	CPAP: Yes <input type="checkbox"/> No <input type="checkbox"/>
		List all surgeries and hospitalizations	Last surgery date:
		List any other medical conditions not covered above	



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Part B: General Information/Health History

Full name: _____
 DOB: _____

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

Allergies/Medications

Are you allergic to or do you have any adverse reaction to any of the following?

Yes	No	Allergies or Reactions	Explain	Yes	No	Allergies or Reactions	Explain
		Medication				Plants	
		Food				Insect bites/stings	

List all medications 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

YES NO Non-prescription medication administration is authorized with these exceptions: _____

Administration of the above medications is approved for youth by:

_____/_____
 Parent/guardian signature MD/DO, NP, or PA signature (if your state requires signature)

! Bring enough medications in sufficient quantities and in the original containers. Make sure that they are NOT expired, including inhalers and EpiPens. You SHOULD NOT STOP taking any maintenance medication unless instructed to do so by your doctor. **!**

Immunization

The following immunizations are recommended by the BSA. Tetanus immunization is required and must have been received within the last 10 years. If you had the disease, check the disease column and list the date. If immunized, check yes and provide the year received.

Yes	No	Had Disease	Immunization	Date(s)	Please list any additional information about your medical history:
			Tetanus		
			Pertussis		
			Diphtheria		
			Measles/mumps/rubella		
			Polio		
			Chicken Pox		
			Hepatitis A		
			Hepatitis B		
			Meningitis		
			Influenza		
			Other (i.e., HIB)		
			Exemption to immunizations (form required)		

DO NOT WRITE IN THIS BOX
 Review for camp or special activity.
 Reviewed by: _____
 Date: _____
 Further approval required: Yes No
 Reason: _____
 Approved by: _____
 Date: _____

Part C: Pre-Participation Physical

This part must be completed by certified and licensed physicians (MD, DO), nurse practitioners, or physician assistants.

Full name: _____

DOB: _____

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

! You are being asked to certify that this individual has no contraindication for participation inside a Scouting experience. For individuals who will be attending a high-adventure program, including one of the national high-adventure bases, please refer to the supplemental information on the following pages or the form provided by your patient. **!**

Examiner: Please fill in the following information:

		Yes	No	Explain							
Medical restrictions to participate											
Yes	No	Allergies or Reactions		Explain		Yes	No	Allergies or Reactions		Explain	
		Medication						Plants			
		Food						Insect bites/stings			

Height (inches): _____ Weight (lbs.): _____ BMI: _____ Blood Pressure: _____ / _____ Pulse: _____

	Normal	Abnormal	Explain Abnormalities
Eyes			
Ears/nose/throat			
Lungs			
Heart			
Abdomen			
Genitalia/hernia			
Musculoskeletal			
Neurological			
Other			

Examiner's Certification

I certify that I have reviewed the health history and examined this person and find no contraindications for participation in a Scouting experience. This participant (with noted restrictions):

True	False	Explain
		Meets height/weight requirements.
		Does not have uncontrolled heart disease, asthma, or hypertension.
		Has not had an orthopedic injury, musculoskeletal problems, or orthopedic surgery in the last six months or possesses a letter of clearance from his or her orthopedic surgeon or treating physician.
		Has no uncontrolled psychiatric disorders.
		Has had no seizures in the last year.
		Does not have poorly controlled diabetes.
		If less than 18 years of age and planning to scuba dive, does not have diabetes, asthma, or seizures.
		For high-adventure participants, I have reviewed with them the important supplemental risk advisory provided.

Examiner's Signature: _____ Date: _____

Provider printed name: _____

Address: _____

City: _____ State: _____ ZIP code: _____

Office phone: _____

Height/Weight Restrictions

If you exceed the maximum weight for height as explained in the following chart and your planned high-adventure activity will take you more than 30 minutes away from an emergency vehicle/accessible roadway, you may not be allowed to participate.

Maximum weight for height:

Height (inches)	Max. Weight	Height (inches)	Max. Weight	Height (inches)	Max. Weight	Height (inches)	Max. Weight
60	166	65	195	70	226	75	260
61	172	66	201	71	233	76	267
62	178	67	207	72	239	77	274
63	183	68	214	73	246	78	281
64	189	69	220	74	252	79 and over	295



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