

Annual BSA Health and Medical Record Part A

GENERAL INFORMATION

Name _____ Date of birth _____ Age _____ Male Female
 Address _____ Grade completed (youth only) _____
 City _____ State _____ Zip _____ Phone No. _____
 Unit leader _____ Council name/No. _____ Unit No. _____
 Social Security No. (optional; may be required by medical facilities for treatment) _____ Religious preference _____
 Health/accident insurance company _____ Policy No. _____

ATTACH A PHOTOCOPY OF BOTH SIDES OF INSURANCE CARD. IF FAMILY HAS NO MEDICAL INSURANCE, STATE "NONE."

In case of emergency, notify:

Name _____ Relationship _____
 Address _____
 Home phone _____ Cell phone _____
 Alternate contact _____ Alternate's phone _____

HEALTH HISTORY

Are you now, or have you ever been treated for any of the following:

| Yes | No | Condition | Explain |
|-----|----|--|---------|
| | | Asthma Last attack: _____ | |
| | | Diabetes Last HbA1c: _____ | |
| | | Hypertension (high blood pressure) | |
| | | Heart disease (e.g., CHF, CAD, MI) | |
| | | Stroke/TIA | |
| | | Lung/respiratory disease | |
| | | Ear/sinus problems | |
| | | Muscular/skeletal condition | |
| | | Menstrual problems (women only) | |
| | | Psychiatric/psychological and emotional difficulties | |
| | | Behavioral disorders (e.g., ADD, ADHD, Asperger syndrome, autism) | |
| | | Bleeding disorders | |
| | | Fainting spells | |
| | | Thyroid disease | |
| | | Kidney disease | |
| | | Sickle cell disease | |
| | | Seizures Last seizure: _____ | |
| | | Sleep disorders (e.g., sleep apnea) Use CPAP: Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| | | Abdominal/digestive problems | |
| | | Surgery | |
| | | Serious injury | |
| | | Other | |

Allergies or Reaction to:

please acknowledge this box, do NOT leave blank. place N/A, if no Allergies

Immunizations:

The following are recommended by the BSA. **Tetanus immunization is required and must have been received within the last 10 years.** If had disease, put "D" and the year. If immunized, check the box and the year received.

| | | |
|--------------------------|--------------------------|------------------------|
| Yes | No | Date |
| <input type="checkbox"/> | <input type="checkbox"/> | Tetanus _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Pertussis _____ |

The words "up to date" with parents initials is sufficient for this block. AS long as the child is enrolled in Howard County Public Schools.

| | | |
|--------------------------|--------------------------|--------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Influenza _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Other (i.e., HIB) _____ |

Exemption to immunizations claimed (form required).

(For more information about immunizations, as well as the immunization exemption form, see Scouting Safely on Scouting.org.)

MEDICATIONS

List all medications currently used. (If additional space is needed, please photocopy this part of the health form.) Inhalers and EpiPen information must be included, even if they are for occasional or emergency use.

| |
|---|
| Medication _____ Strength _____ Frequency _____ Approximate date started _____ Reason for medication _____ |
| Medication _____ Strength _____ Frequency _____ Approximate date started _____ Reason for medication _____ |

All Medication MUST be in original container with scouts name on the label, placed in a GALLON sized zip lock bag with Child Name, Home Pack Number, Contact Number. if Medication is to be administered daily at camp, please put instructions such as dosage and time.
If medication is for emergency use such as FAI or Epi please note Emergency Use only on the zip lock.
Please ensure the blocks are filled out for each medication and a parent signs below. Loose pills in a zip lock will not be accepted or administered.

Administration of the above medications is approved by (if required by your state): _____ / _____
 Parent/guardian signature and/or MD/DO, NP, or PA signature

Any questions in reference to this form or sickbay can be directed to daycampmedical@verizon.net

Signatures and the original containers. Make sure that they are NOT TO BE DESTROYED. YOU SHOULD NOT STOP taking any maintenance medication.

Emergency contact No.:

Allergies:

DOB:

Full name:

Please put PACK / Troop number in corner with black marker... This is the number your son has on his uniform shirt sleeve

Please put information that we can QUICKLY get in touch with someone in case of emergency

please acknowledge this box, do NOT leave blank. place N/A, if no Allergies

The words "up to date" with parents initials is sufficient for this block. AS long as the child is enrolled in Howard County Public Schools.

All Medication MUST be in original container with scouts name on the label, placed in a GALLON sized zip lock bag with Child Name, Home Pack Number, Contact Number. if Medication is to be administered daily at camp, please put instructions such as dosage and time.
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Please ensure the blocks are filled out for each medication and a parent signs below. Loose pills in a zip lock will not be accepted or administered.

Part B

INFORMED CONSENT AND HOLD HARMLESS/RELEASE AGREEMENT

High-adventure base participant

Expedition/crew No.: _____

or staff position: _____

Pack / Troop Number in
marker

I understand that participation in Scouting activities involves a certain degree of risk and can be physically, mentally, and emotionally demanding. I also understand that participation in these activities is entirely voluntary and requires participants to abide by applicable rules and standards of conduct.

In case of an emergency involving me or my child, I understand that every effort will be made to contact the individual listed as the emergency contact person. 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.

I have carefully considered the risk involved and give consent for myself and/or my child to participate in these activities. I approve the sharing of the information on this form with BSA volunteers and professionals who need to know of medical situations that might require special consideration for the safe conducting of Scouting activities.

I 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 claims or liability arising out of this participation.

Without restrictions.

With special considerations or restrictions (list) _____

TALENT RELEASE AGREEMENT

I hereby assign and grant to the local council and the Boy Scouts of America 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 hereby 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 Boy Scouts of America, and I specifically waive any right to any compensation I may have for any of the foregoing.

Yes No

ADULTS AUTHORIZED TO TAKE YOUTH TO AND FROM EVENTS:

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

1. Name _____ Telephone _____

2. Name _____ Telephone _____

3. Name _____ Telephone _____

Adults NOT authorized to take youth to and from events:

1. Name _____

2. Name _____

3. Name _____

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, or Florida Sea Base: I have also read and understand the risk advisories explained in Part D, *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.

Participant's name _____

Participant's signature _____ Date _____

Parent/guardian's signature _____
(if participant is under the age of 18)

Second parent/guardian signature _____
(if required; for example, CA)

This version is the ONLY version that will be accepted. Previous versions are obsolete.

This Annual Health and Medical Record is valid for 12 calendar months.

Part B Full name: _____ DOB: _____

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