

PERSONAL HEALTH AND MEDICAL RECORD FORM—Class 3

I. IDENTIFICATION Age _____ Sex _____ Date of Birth _____

Name _____
Last Name First Name Initial

Address _____

City & State _____ Zip _____

Health/Accident insurance _____ Policy no. _____

IN AN EMERGENCY NOTIFY:

Name _____ Relationship _____

Address _____ Home phone () _____ - _____

City & State _____ Business phone () _____ - _____

Cell Phone () _____ - _____

Other Emergency Contact

Home phone () _____ - _____

Business () _____ - _____ Cell Phone () _____ - _____

**BOY SCOUTS OF AMERICA
FOR SUMMER CAMP AT READ SCOUT RESERVATION**

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 section VII 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: _____

All prescribed medications must be in the original container and properly labeled by a physician or pharmacist. Ensure enough medication is provided for the length of the applicants stay in camp. All medication left at camp will be destroyed within one week after the applicant leaves camp.

I have reviewed and to the best of my knowledge, the information in sections I, II, III, IV, V, and X is accurate and complete. I request a licensed health-care professional to examine applicant, to give needed immunizations and to furnish 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. I give permission for camp personnel to administer the prescription medications that I send to camp with my child.

This Personal Health and Medical Record is treated as confidential. Medical information may be shared with necessary staff members to insure the health and safety of the applicant. I agree that images my son may be used in camp promotional materials.

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

Date signed _____

IV. IMMUNIZATIONS

If have had disease, put "D" and Year

Last date given

Tetanus ___/___/___

Diphtheria ___/___/___

Pertussis ___/___/___

Measles ___/___/___

Mumps ___/___/___

Rubella ___/___/___

Polio ___/___/___

Chicken Pox ___/___/___

Hepatitis B ___/___/___

Haemophilus

Influenza - B ___/___/___

Religious preference _____

V. MEDICAL HISTORY

Parent (or applicant if 18 or older): Fill in sections I, II, III, IV and V 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 any injuries, 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 PRESENT 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"/>	_____	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
High Blood Pressure	<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"/>	_____	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Other (explain)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

VI. IMPORTANT NOTICE FOR ALL CAMPERS ATTENDING A NEW YORK STATE CAMP FOR MORE THAN 7 NIGHTS

New York State legislation passed in 2003 requires all camps to provide information on meningitis to all families of campers who attend camp for more than seven nights. The law also requires parents of these campers to acknowledge receipt of this information and indicate whether or not the camper has been immunized against meningitis.

The required response form must be attached to this form in order for any camper to attend camp for more than seven nights.

If your child will be camping with us for more than seven nights and the information and response form are not attached to this medical record, please contact the camping office at 914-773-1135. The information and response form can also be downloaded from wpcbsa.org

Thank you for your assistance in this important matter regarding your child's health.

VII. ADDITIONAL NOTES

Health/Accident Insurance Company _____

Policy # _____ We do not have insurance

NAME _____ UNIT _____
NOTE: Keep original form for your personal record. Make reproductions for agency use. Be sure information and signatures are legible on reproduced copies. This upper section may be reproduced and carried with you for emergency identification and care.

VIII. 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 (V) 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 VIII, summarize any restrictions and/or recommendations in sections II and X, review section IX, list medication(s) and strike any medication not approved for use and sign.

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

Check box if normal; circle if abnormal and give details below:

- | | | |
|--|---|--|
| <input type="checkbox"/> Growth, development | <input type="checkbox"/> Teeth, tonsils | <input type="checkbox"/> Genitourinary |
| <input type="checkbox"/> Skin, glands, hair | <input type="checkbox"/> Respiratory | <input type="checkbox"/> Skeletomuscular |
| <input type="checkbox"/> Head, neck, thyroid | <input type="checkbox"/> Cardiovascular | <input type="checkbox"/> Neuropsychiatry |
| <input type="checkbox"/> Eyes, ears, nose | <input type="checkbox"/> Abdomen, hernia, rings | <input type="checkbox"/> Other (specify) |

Comments _____

LABORATORY: Urinalysis (dip stick) Albumin _____ Sugar _____

For Those Attending Philmont, National High-Adventure Bases OR Summit Base at the Read Scout Reservation:
 * 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.

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IX. HEALTH-CARE PRACTITIONER MEDICATION ORDERS

Applicant takes the following medication(s):

Med. #1 _____ Dosage _____ Times _____
 Med. #2 _____ Dosage _____ Times _____

To note additional medications or give more detailed information use section VII or attach additional page(s). Identify any medication(s) taken during the school year that applicant does/may not take during the summer.

The camp Medical Officer may give the following over the counter medications as per label instructions based on age and weight:

- | | |
|------------------------|--------------------------------------|
| -Diphenhydramine USP | -Topical Tinactin Liquid or powder |
| -Chlorotremeton | -Chloraseptic Gargle (or equivalent) |
| -Ivarest Topical | -Caladryl Topical |
| -Calamine Topical | -Topical Hydrocortisone 0.5% cream |
| -Guiatuss (Robitussin) | -Keopectate |
| -Novafed | -Sudafed |
| -Actifed | -Ibuprophen |
| -Acetaminophen | -Other _____ |

Strike out any medication that should not be given

X. LICENSED HEATH-CARE PRACTITIONER'S EVALUATION & ADVICE

Approved for participation in:

- | | |
|---|---|
| <input type="checkbox"/> Hiking and camping | <input type="checkbox"/> Water activities |
| <input type="checkbox"/> Competitive sports | <input type="checkbox"/> All activities |

Specify exceptions _____

Recommendations (explain any restrictions or limitations): _____

Health Care Providers Name _____

Phone _____ Date _____

Signed _____
 Licensed health-care practitioner

Examinations conducted by licensed health-care practitioners 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.

FOR CAMP USE ONLY

MEDICAL RE-CHECK Date _____

Allergies Yes No _____ Restrictions Yes No _____
 Medications Yes No _____ Medical Alert Yes No _____
 Feels Today _____ New Condition _____

Notes:

MEDICAL RE-CHECK Date _____

Allergies Yes No _____ Restrictions Yes No _____
 Medications Yes No _____ Medical Alert Yes No _____
 Feels Today _____ New Condition _____

Notes:

MEDICAL RE-CHECK Date _____

Allergies Yes No _____ Restrictions Yes No _____
 Medications Yes No _____ Medical Alert Yes No _____
 Feels Today _____ New Condition _____

Notes: