

# Annual BSA Health and Medical Record Part A

## GENERAL INFORMATION

### High-adventure base participants:

Expedition/crew No.: \_\_\_\_\_  
or staff position: \_\_\_\_\_

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 \_\_\_\_\_ Business 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:

Medication \_\_\_\_\_  
 Food, Plants, or Insect Bites \_\_\_\_\_

### 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"/>	<b>Tetanus</b> _____
<input type="checkbox"/>	<input type="checkbox"/>	Pertussis _____
<input type="checkbox"/>	<input type="checkbox"/>	Diphtheria _____
<input type="checkbox"/>	<input type="checkbox"/>	Measles _____
<input type="checkbox"/>	<input type="checkbox"/>	Mumps _____
<input type="checkbox"/>	<input type="checkbox"/>	Rubella _____
<input type="checkbox"/>	<input type="checkbox"/>	Polio _____
<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"/>	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 only.

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

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

**Be sure to bring medications in sufficient quantities and the original containers. Make sure that they are NOT expired, including inhalers and EpiPens. You SHOULD NOT STOP taking any maintenance medication.**

Emergency contact No.:

Allergies:

DOB:

Full name:

## Part B

### INFORMED CONSENT AND HOLD HARMLESS/RELEASE AGREEMENT

#### High-adventure base participants:

Expedition/crew No.: \_\_\_\_\_  
or staff position: \_\_\_\_\_

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 \_\_\_\_\_ Date \_\_\_\_\_

(if participant is under the age of 18)

Second parent/guardian signature \_\_\_\_\_ Date \_\_\_\_\_

(if required; for example, CA)

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

**Part B Full name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**High-adventure base participants:**  
 Expedition/crew No.: \_\_\_\_\_  
 or staff position: \_\_\_\_\_

**Part C**

**TO THE EXAMINING HEALTH-CARE PROVIDER** (Certified and licensed physicians [MD, DO], nurse practitioners, and physician's assistants)

You are being asked to certify that this individual has no contraindication for participation in a Scouting experience. For individuals who will be attending a high-adventure program at one of the national high-adventure bases, please refer to Part D for additional information.

(Part D was made available to me.  Yes  No)

**PHYSICAL EXAMINATION**

Height (inches) \_\_\_\_\_ Weight (pounds) \_\_\_\_\_ Maximum weight for height \_\_\_\_\_ Meets height/weight limits  Yes  No  
 Blood pressure \_\_\_\_\_ Pulse \_\_\_\_\_ Percent body fat (optional) \_\_\_\_\_

If you exceed the maximum weight for height as explained on this page and your planned high-adventure activity will take you more than 30 minutes away from an emergency vehicle-accessible roadway, you **will not** be allowed to participate. At the discretion of the medical advisors of the event and/or camp, participation of an individual exceeding the maximum weight for height may be allowed if the body fat percentage measured by the health-care provider is determined to be 20 percent or less for a female or 15 percent or less for a male. (Philmont requires a water-displacement test to be used for this determination.) Please call the event leader and/or camp if you have any questions. Enforcing the height/weight guidelines is strongly encouraged for all other events.

	Normal	Abnormal	Explain Any Abnormalities	Range of Mobility	Normal	Abnormal	Explain Any Abnormalities
Eyes				Knees (both)			
Ears				Ankles (both)			
Nose				Spine			
Throat							
Lungs							
Neurological				<b>Other</b>	<b>Yes</b>	<b>No</b>	
Heart				Contacts			
Abdomen				Dentures			
Genitalia				Braces			
Skin				Inguinal hernia			<b>Explain</b>
Emotional adjustment				Medical equipment (i.e., CPAP, oxygen)			
Tuberculosis (TB) skin test (if required by your state for BSA camp staff) <input type="checkbox"/> Negative <input type="checkbox"/> Positive							

**Allergies** (to what agent, type of reaction, treatment): \_\_\_\_\_

**Restrictions** (if none, so state) \_\_\_\_\_

**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 above)

**True False**

- 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 their 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

Provider printed name \_\_\_\_\_

Address \_\_\_\_\_

City, state, zip \_\_\_\_\_

Office phone \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

Height (inches)	Recommended Weight (lbs)	Allowable Exception	Maximum Acceptance
60	97-138	139-166	166
61	101-143	144-172	172
62	104-148	149-178	178
63	107-152	153-183	183
64	111-157	158-189	189
65	114-162	163-195	195
66	118-167	168-201	201
67	121-172	173-207	207
68	125-178	179-214	214
69	129-185	186-220	220
70	132-188	189-226	226
71	136-194	195-233	233
72	140-199	200-239	239
73	144-205	206-246	246
74	148-210	211-252	252
75	152-216	217-260	260
76	156-222	223-267	267
77	160-228	229-274	274
78	164-234	235-281	281
79 & over	170-240	241-295	295

This table is based on the revised Dietary Guidelines for Americans from the U.S. Dept. of Agriculture and the Dept. of Health & Human Services.

**DO NOT WRITE IN THIS BOX**

REVIEW FOR CAMP OR SPECIAL ACTIVITY

Reviewed by \_\_\_\_\_ Date \_\_\_\_\_

Further approval required  Yes  No Reason \_\_\_\_\_

By \_\_\_\_\_ Date \_\_\_\_\_

**Part C Full name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_



**TEN MILE RIVER SCOUT CAMPS**  
**GREATER NEW YORK COUNCILS**

www.tenmileriver.org

Individualized Medication Orders  
STANDARD OVER-THE-COUNTER/PRN MEDICATIONS

CAMPER NAME: \_\_\_\_\_ UNIT: \_\_\_\_\_ CAMP: \_\_\_\_\_

CAMPER WEIGHT: \_\_\_\_\_ lbs.      DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_

HEALTHCARE PROVIDER NAME: \_\_\_\_\_ LICENSE #: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

HEALTHCARE PROVIDER SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

I recognize that this is a two-page document

HEALTHCARE PROVIDER STAMP:

**By order of the NYS Department of Health, this form is required for all campers under 18 years of age, and must be accompanied by a completed Annual BSA Health and Medical Record Form.**

The following medications are available in the camp Health Lodge and will be administered at the discretion of the camp Medical Officer, **if approval** is ordered by the Healthcare Provider below.

**Do not send these medications to camp; they are at the Health Lodge**

DRUG NAME	ROUTE <i>circle preferred formulation</i>	DOSAGE	SCHEDULE	PROVIDER ORDER <i>check one</i>	COMMENTS
BENADRYL (25 to 50 mg)	PO (elixir, chewable tabs, pills)	Per label instructions by age/weight	Q 6 hr prn for allergic reaction (hives, insect bite)	<input type="checkbox"/> YES <input type="checkbox"/> NO	
CEPACOL	PO (lozenges)	Per label instructions by age/weight	Q 2 hr for sore throat (no > 4 doses in 24 hr and no fever)	<input type="checkbox"/> YES <input type="checkbox"/> NO	
CHILDREN'S DIMETAPP COLD & ALLERGY	PO (elixir, tabs)	Per label instructions by age/weight	Q 6-8 hr prn for nasal congestion/drainage	<input type="checkbox"/> YES <input type="checkbox"/> NO	
IBUPROFEN (200 to 400 mg)	PO (chewable tabs, suspension, tabs)	Per label instructions by age/weight	Q 6 hr prn for pain or fever > _____ °F	<input type="checkbox"/> YES <input type="checkbox"/> NO	
MYLANTA	PO (chewable tabs)	Per label instructions by age/weight	TID prn for stomach upset	<input type="checkbox"/> YES <input type="checkbox"/> NO	
CHILDREN'S PEPTO BISMOL	PO (liquid, chewable tabs)	Per label instructions by age/weight	TID prn for stomach upset (no > 4 doses in 24 hr)	<input type="checkbox"/> YES <input type="checkbox"/> NO	
ROBITUSSIN	PO (syrup)	Per label instructions by age/weight	Q 4 hr prn for cough	<input type="checkbox"/> YES <input type="checkbox"/> NO	

**Individualized Medication Orders**  
**STANDARD OVER-THE-COUNTER/PRN MEDICATIONS**

CAMPER NAME: \_\_\_\_\_ UNIT: \_\_\_\_\_ CAMP: \_\_\_\_\_

DRUG NAME	ROUTE <i>circle preferred formulation</i>	DOSAGE	SCHEDULE	PROVIDER ORDER <i>check one</i>	COMMENTS
TYLENOL	PO (chewable tabs, elixir, tabs)	Per label instructions by age/weight	Q 4 hr prn for pain or fever > _____ °F	<input type="checkbox"/> YES <input type="checkbox"/> NO	
CALADRYL	Topical	Per label instructions by age/weight	as directed for itches, bites, skin irritations, rashes	<input type="checkbox"/> YES <input type="checkbox"/> NO	
BACITRACIN OINTMENT	Topical	Per label instructions by age/weight	as directed for minor cuts and abrasions	<input type="checkbox"/> YES <input type="checkbox"/> NO	
TINACTIN (or equivalent)	Topical (liquid, powder)	Per label instructions by age/weight	as directed for athlete's foot, jock itch, fungal rash	<input type="checkbox"/> YES <input type="checkbox"/> NO	

The medications above are the **only medications** that are available in the camp Health Lodge. If additional over-the-counter medications are required, the camper's parent/guardian must make arrangements to procure and send these medications to camp with the camper's unit leader. The Healthcare Provider should list any such medications below.

**SELF-PROVIDED OVER-THE-COUNTER/PRN MEDICATIONS**

*please strike-out this section if not needed*

				<input type="checkbox"/> YES <input type="checkbox"/> NO	
				<input type="checkbox"/> YES <input type="checkbox"/> NO	
				<input type="checkbox"/> YES <input type="checkbox"/> NO	