

**PERSONAL HEALTH AND MEDICAL RECORD FORM – CLASS 3**

**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.

**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: \_\_\_\_\_

**GENERAL INFORMATION**

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.

**All prescribed medication 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 at camp. All medication left at camp will be destroyed within one week after applicant leaves camp.**

**Additional Notes:**

\_\_\_\_\_

\_\_\_\_\_

**Health/Accident Insurance Company:**

\_\_\_\_\_

**Policy #** \_\_\_\_\_     **We do not have insurance**

**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, and VI, 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 \_\_\_\_\_

**IMMUNIZATIONS**

If disease, put "D" and year,                      Last date given

Tetanus                      / /  
 Diphtheria                      / /  
 Pertussis                      / /  
 Measles                      / /  
 Mumps                      / /  
 Rubella                      / /  
 Polio                      / /  
 Chicken Pox                      / /  
 Hepatitis B                      / /  
 Haemophilus                      / /  
 Influenza – B                      / /

Religious preference \_\_\_\_\_

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. The upper section may be reproduced

**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 Camping Services at (212) 651-2955. The information and response form can also be downloaded from [tenmileriver.org](http://tenmileriver.org).

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

**FOR CAMP USE ONLY**

**MEDICAL RE-CHECK**

Allergies     Yes     No \_\_\_\_\_                      Restrictions     Yes     No \_\_\_\_\_

Medications     Yes     No \_\_\_\_\_                      Medical Alert     Yes     No \_\_\_\_\_

Feels Today \_\_\_\_\_                      New Condition \_\_\_\_\_

Emergency contact information verified  \_\_\_\_\_

Notes: \_\_\_\_\_

**MEDICAL RE-CHECK**

Allergies     Yes     No \_\_\_\_\_                      Restrictions     Yes     No \_\_\_\_\_

Medications     Yes     No \_\_\_\_\_                      Medical Alert     Yes     No \_\_\_\_\_

Feels Today \_\_\_\_\_                      New Condition \_\_\_\_\_

Emergency contact information verified [ ] \_\_\_\_\_                      Notes: \_\_\_\_\_

# FOR USE AT GREATER NEW YORK COUNCILS CAMPS

## 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 before exam.

Review immunizations (**over**): 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.

**Summarize any restrictions and/or recommendations below, review medication orders, list medication(s) and strike any medication not approved for use and sign.**

**VISION:                      HEARING:**

Date \_\_\_\_\_ Normal \_\_\_\_\_ Normal \_\_\_\_\_  
 Ht. \_\_\_\_\_ Glasses \_\_\_\_\_ Abnormal \_\_\_\_\_  
 Wt. \_\_\_\_\_ Contacts \_\_\_\_\_  
 B.P. \_\_\_\_\_/\_\_\_\_\_ Pulse \_\_\_\_\_

**Check box if normal; circle if abnormal & give details below:**

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

Comments \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**LABORATORY: Urinalysis (dip stick)** Albumin \_\_\_\_\_ Sugar \_\_\_\_\_

**LICENSED HEATH-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 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 X 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. **Strike out any medication that should not be given**

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

**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.

## MEDICAL HISTORY

**Parent (or applicant if 18 or older):** Fill in front sections 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):**

Details:	No	Yes	Date
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"/>	_____
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"/>	_____

*Revised 1/2009*

Please ensure both sides are completed.

## **Meningococcal Disease**

### *Information for College Students and Parents of Children at Residential Schools and Overnight Camps*

#### **What is meningococcal disease?**

Meningococcal disease is a severe bacterial infection of the bloodstream or meninges (a thin lining covering the brain and spinal cord).

#### **Who gets meningococcal disease?**

Anyone can get meningococcal disease, but it is more common in infants and children. For some college students, such as freshmen living in dormitories, there is an increased risk of meningococcal disease. Between 100 and 125 cases of meningococcal disease occur on college campuses every year in the United States; between 5 and 15 college students die each year as result of infection. Currently, no data are available regarding whether children at overnight camps or residential schools are at the same increased risk for disease. However, these children can be in settings similar to college freshmen living in dormitories. Other persons at increased risk include household contacts of a person known to have had this disease, and people traveling to parts of the world where meningitis is prevalent.

#### **How is the germ meningococcus spread?**

The meningococcus germ is spread by direct close contact with nose or throat discharges of an infected person. Many people carry this particular germ in their nose and throat without any signs of illness, while others may develop serious symptoms.

#### **What are the symptoms?**

High fever, headache, vomiting, stiff neck and a rash are symptoms of meningococcal disease. Among people who develop meningococcal disease, 10-15% die, in spite of treatment with antibiotics. Of those who live, permanent brain damage, hearing loss, kidney failure, loss of arms or legs, or chronic nervous system problems can occur.

#### **How soon do the symptoms appear?**

The symptoms may appear 2 to 10 days after exposure, but usually within 5 days.

#### **What is the treatment for meningococcal disease?**

Antibiotics, such as penicillin G or ceftriaxone, can be used to treat people with meningococcal disease.

#### **Is there a vaccine to prevent meningococcal meningitis?**

Yes, a safe and effective vaccine is available. The vaccine is 85% to 100% effective in preventing four kinds of bacteria (serogroups A, C, Y, W-135) that cause about 70% of the disease in the United States. The vaccine is safe, with mild and infrequent side effects, such as redness and pain at the injection site lasting up to 2 days. After vaccination, immunity develops within 7 to 10 days and remains effective for approximately 3 to 5 years. As with any vaccine, vaccination against meningitis may not protect 100% of all susceptible individuals.

#### **How do I get more information about meningococcal disease and vaccination?**

Contact your family physician or your student health service. Additional information is also available on the websites of the New York State Department of Health, [www.health.state.ny.us](http://www.health.state.ny.us); the Centers for Disease Control and Prevention [www.cdc.gov/ncidod/dbmd/diseaseinfo/meningococcal\\_g.htm](http://www.cdc.gov/ncidod/dbmd/diseaseinfo/meningococcal_g.htm) or [www.cdc.gov/vaccines/spec-grps/preteens-adol/info-parents.htm#mening](http://www.cdc.gov/vaccines/spec-grps/preteens-adol/info-parents.htm#mening) and the American College Health Association, [www.acha.org](http://www.acha.org).

Dear Parent:

I am writing to inform you about meningococcal disease, a potentially fatal bacterial infection commonly referred to as meningitis, and a new law in New York State. On July 22, 2003, the New York State Public Health Law (NYS PHL) was amended to include §2167 requiring overnight children's camps to distribute information about meningococcal disease and vaccination to the parents or guardians of all campers who attend camp for 7 or more nights. This law became effective on August 15, 2003.

Ten Mile River Scout Camps are required to maintain a record of the following for each camper:

- A response to receipt of meningococcal meningitis disease and vaccine information signed by the camper's parent or guardian; AND
- Information on the availability and cost of meningococcal meningitis vaccine (Menomune™); AND EITHER
- A record of meningococcal meningitis immunization within the past 10 years; OR
- An acknowledgement of meningococcal meningitis disease risks and refusal of meningococcal meningitis immunization signed by the camper's parent or guardian.

Meningitis is rare. However, when it strikes, its flu-like symptoms make diagnosis difficult. If not treated early, meningitis can lead to swelling of the fluid surrounding the brain and spinal column as well as severe and permanent disabilities, such as hearing loss, brain damage, seizures, limb amputation and even death.

Cases of meningitis among teens and young adults 15 to 24 years of age have more than doubled since 1991. The disease strikes about 3,000 Americans each year and claims about 300 lives.

A vaccine is available that protects against four types of the bacteria that cause meningitis in the United States — types A, C, Y and W-135. These types account for nearly two thirds of meningitis cases among teens and young adults.

Information about the availability and cost of the vaccine can be obtained from your health care provider and by visiting the manufacturer's website at [www.meningitisvaccine.com](http://www.meningitisvaccine.com). Ten Mile River Scout Camps *do not offer MENINGOCOCCAL IMMUNIZATION SERVICES*.

For all Scouts attending camp for more than one week, **Please complete the Meningococcal Vaccination Response Form on the reverse side. This form should remain attached to your child's medical form and be brought to the camp.**

To learn more about meningitis and the vaccine, please feel free to contact Camping Services at 212-651-2955, visit [tenmileriver.org](http://tenmileriver.org) and/or consult your child's physician. You can also find information about the disease at the New York State Department of Health website: [WWW.HEALTH.STATE.NY.US](http://WWW.HEALTH.STATE.NY.US), and the website of the Center for Disease Control and Prevention (CDC): [WWW.CDC.GOV/NCIDOD/DBMD/DISEASEINFO](http://WWW.CDC.GOV/NCIDOD/DBMD/DISEASEINFO).

# MENINGOCOCCAL MENINGITIS VACCINATION RESPONSE FORM

New York State Public Health Law requires the operator of an overnight children's camp to maintain a completed response form for every camper who attends camp for seven (7) or more nights.

**Check one box and sign below.**

My child has had the meningococcal meningitis immunization (Menomune™) within the past 10 years. Date received: \_\_\_\_\_

[Note: The vaccine's protection lasts for approximately 3 to 5 years. Revaccination may be considered within 3-5 years.]

I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that my child will **not** obtain immunization against meningococcal meningitis disease.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Parent / Guardian)

Camper's Name: \_\_\_\_\_ Date of Birth : \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Parent/Guardian's E-mail address (optional): \_\_\_\_\_