



PERSONAL HEALTH AND MEDICAL RECORD

CLASS 1

Class 1 (update annually for all participants). Activity: Day camp, overnight hike, or other programs not exceeding 72 hours, with level of activity similar to that of home or school. Medical care is readily available. Current personal health and medical summary (history) is attested by parents to be accurate. This form is filled out by all participants and is on file for easy reference.

Note: Some states require an **annual** precamp medical evaluation. Your BSA local council service center can advise you about the requirements for your state.

CLASS 1 PERSONAL HEALTH AND MEDICAL HISTORY

(To be filled out annually by all participants)

To be filled out by parent, guardian, or adult participant. Please print in ink.

IDENTIFICATION

Name _____ Date of birth _____ Age _____ Sex _____

Name of parent or guardian _____ Telephone _____

Home address _____ City _____ State _____ Zip _____

Business address _____ City _____ State _____ Zip _____

If person above is not available in the event of an emergency, notify

Name _____ Relationship _____ Telephone _____

Name _____ Relationship _____ Telephone _____

Personal health/accident insurance carrier _____ Telephone _____

Check all items that apply, **past or present**, to your health history. Explain any "Yes" answers.

ALLERGIES: Food, medicines, insects, plants Yes No

GENERAL INFORMATION:	Yes	No		Yes	No		Yes	No
ADHD (Attention-Deficit Hyperactivity Disorder)	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>

Explain: _____

Please list ALL medications taken in the 30 days **prior** to arrival at the Scouting activity where this form is to be used: _____

List any medications to be taken at camp: _____

List any physical or behavioral conditions that may affect or limit full participation in swimming, backpacking, hiking long distances, or playing strenuous physical games: _____

List equipment needed such as wheelchair, braces, glasses, contact lenses, etc.: _____

IMMUNIZATIONS: (Give date of last inoculation.)

Tetanus toxoid _____ Measles _____ Polio _____

Diphtheria _____ Mumps _____

Pertussis _____ Rubella _____

I give permission for full participation in BSA programs, subject to limitations noted herein

In case of emergency, I understand every effort will be made to contact me (if participant is an adult, my spouse or next of kin). In the event I cannot be reached, I hereby give permission to licensed health-care practitioner selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, or injections of medication for my child (or for me, if participant is an adult).

Date _____ Signature of parent/guardian or adult _____

Some hospitals require the parent/guardian signature to be notarized. Check with your BSA local council service center.

NAME

TROOP

CAMP SITE





PERSONAL HEALTH AND MEDICAL RECORD

CLASS 2

If your child has had a medical evaluation (**physical examination**) within the last 36 months, a copy of the results of this examination must be attached to the health history for all participants in a camping experience lasting longer than 72 consecutive hours. If a copy is not available, a physical examination (using the Class 2 section of this form) must be scheduled by a *licensed health-care practitioner. This medical evaluation (physical examination) also is required if your child is currently under medical care, takes a prescription medication, requires a medically prescribed diet, has had an injury or illness during the past 6 months that limited activity for a week or more, has ever lost consciousness during physical activity, or has suffered a concussion from a head injury.

Note: Some states require an **annual** precamp medical evaluation. Your BSA local council service center can advise you about the requirements for your state.

* 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.

THIS FORM IS NOT TO BE USED BY ADULTS OVER 40, BY HIGH ADVENTURE PARTICIPANTS (USE FORM NO. 34412A), OR FOR NATIONAL SCOUT JAMBOREE (USE FORM NSJ-34412-97).

CLASS 2 MEDICAL EVALUATION

(Read additional requirements outlined on the top of this form.)

Name _____ Date of birth _____ Age _____ Sex _____

NOTE TO LICENSED HEALTH-CARE PRACTITIONERS*: The person being evaluated will be attending one or more weeks of camp that may include sleeping on the ground and participating in strenuous activities such as hiking, boating, and vigorous group games. Please review the health history with the participant for any interim changes. **Explain any "abnormal" evaluations.**

PHYSICAL EXAMINATION (To be filled out by a licensed health-care practitioner*)

Height _____ Weight _____ BP _____ Pulse _____

VISION: Normal _____ Glasses _____ Contacts _____

HEARING: Normal _____ Abnormal _____ Explain _____

Check Box:	N	Abn		N	Abn		N	Abn
Growth Development	<input type="checkbox"/>	<input type="checkbox"/>	Teeth	<input type="checkbox"/>	<input type="checkbox"/>	Genitalia	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>	Cardiopulmonary system	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>
HEENT	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Neurobehavioral	<input type="checkbox"/>	<input type="checkbox"/>

Explain: _____

LIMITATIONS

Activity Restrictions: _____

Diet Restrictions: _____

Signature _____ Date _____
Licensed Health-Care Practitioner*

Address _____ Phone _____

City, State, Zip _____

* **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.**

INTERVAL RECORD	(CAMP, CAMPOREE, TOURNAMENT, TRAVEL, ETC.)	
DATE, TIME, PLACE, ETC.	FINDINGS, DIAGNOSES, TREATMENT, INSTRUCTIONS, DISPOSITION, ETC.	BY:

NAME

TROOP

CAMP SITE

PERSONAL HEALTH AND MEDICAL RECORD FORM - Class 3

I. IDENTIFICATION

Name _____
 Last Name First Name Initial Mo Day Year
 Address _____
 City & State _____ Zip _____
 Health/Accident Insurance _____ Policy No. _____

IN AN EMERGENCY NOTIFY:

Name _____ Relationship _____
 Address _____ Home _____
 City & State _____ Work _____
 Personal Physician _____ Phone _____

III. PARENTAL STATEMENT

Has it ever been necessary to restrict applicants activities for medical reason? No Yes Does applicant take medicine regularly or have special care? No Yes If yes explain.

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 full 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 _____

IV. IMMUNIZATIONS

If disease, put "D" and year

Last Year Given
 Tetanus _____
 Diphtheria _____
 Pertussis _____
 Measles _____
 Mumps _____
 Rubella _____
 Polio _____
 Chicken Pox _____

Religious Preference _____

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 all adults over 40 for all activities requiring a physical examination and applies to all Wood Badge participants/staff regardless of age.

II. EMERGENCY MEDICAL INFORMATION

Has or is subject to (check and give details):

- 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 Convulsions Heart Trouble Contact Lenses
- Diabetes Fainting Spells Bleeding Disorders Dentures

EXPLAIN _____

V. LICENSED HEALTH-CARE PRACTITIONER'S EVALUATION AND ADVICE

Approved for participation in:

- Hiking and Camping Water Activities
- Competitive Sports All Activities

Specify Exceptions _____

Recommendations (explain any restrictions OR limitations): _____

Signed _____ Date _____

* Licensed health-care practitioner

*Examinations conducted by licensed health-care practitioner 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.

VI. MEDICAL HISTORY

Parent (or applicant if 18 or older): Fill in sections I, II, III, IV, and VI 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 and year) _____ 20 _____
- Are you aware of any current health problems? No Yes
- Now under medical care or taking medicines? No Yes
- Has there been any surgery, injury, illness, allergy, or change in health status since the last complete physical examination? No Yes

Give dates and full details below for any "yes" answers

IS THERE DISEASE OF (OR PAST OR PRESENT HISTORY OF):

	No	Yes	Year	Details/Medicines
Serious 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"/>	_____	_____
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"/>	_____	_____
Other (explain)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

VII. HEALTH EXAMINATION

Licensed Health-Care Practitioner

The applicant will be participating in a strenuous activity that will include one or more of the following conditions, athletic competition, 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 secured.

- Please insist applicant furnish complete medical history (VI) 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 had tetanus booster within 10 years. A measles booster is recommended at age 12.
- After completing section VII, summarize any restrictions and/or recommendations in sections II and V, above and sign.

VISION HEARING
 Date _____ Normal _____ Normal _____
 Ht _____ Wt _____ Glasses _____ Abnormal _____
 BP _____ Pulse _____ Contacts _____

Check box if normal, circle if abnormal and give details below

- Growth, development Teeth, tonsils Genitourinary
- Skin, glands, hair Respiratory Skeletomuscular
- Head, neck, thyroid Cardiovascular Neuropsychiatric
- Eyes, ears, nose Abdomen, hernia, rings Other (specify)

COMMENTS _____

FOR THOSE ATTENDING PHILMONT OR NATIONAL HIGH ADVENTURE BASES:

* The minimum age for all participants is 13 by January 1 of the year of participation, or have completed the seventh grade. 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 high -adventure bases reserve the right to deny access to the trails or other program activity on the basis of a medical evaluation performed at the base after arrival.

PLEASE TYPE OR PRINT

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.

REVIEW FOR CAMP OR SPECIAL ACTIVITY

DATE	AGENCY AND ACTIVITY	BY	"OK"	PHYSICIAN RECHECK NEEDED	RESULTS OF RECHECK	INITIAL

INTERVAL RECORD	(CAMP, CAMPOREE, TOURNAMENT, TRAVEL, ETC.)	
DATE, TIME, PLACE, ETC.	FINDINGS, DIAGNOSES, TREATMENT, INSTRUCTIONS, DISPOSITION, ETC.	BY: