NOTE: Complete Medical Record form (w/Dr. Signature) for Owasippe Camps & Reneker Family Camp.

Annual Health and Medical Record

(Valid for 12 calendar months)

Medical Information

The Boy Scouts of America recommends that all youth and adult members have annual medical evaluations by a certified and licensed health-care provider. In an effort to provide better care to those who may become ill or injured and to provide youth members and adult leaders a better understanding of their own physical capabilities, the Boy Scouts of America has established minimum standards for providing medical information prior to participating in various activities. Those standards are offered below in one three-part medical form. Note that unit leaders must always protect the privacy of unit participants by protecting their medical information.

Parts A and C are to be completed annually **by all BSA unit members.** Both parts are required for all events that do not exceed 72 consecutive hours, where the level of activity is similar to that normally expended at home or at school, such as day camp, day hikes, swimming parties, or an overnight camp, and where medical care is readily available. Medical information required includes a current health history and list of medications. Part C also includes the parental informed consent and hold harmless/release agreement (with an area for notarization if required by your state) as well as a talent release statement. Adult unit leaders should review participants' health histories and become knowledgeable about the medical needs of the youth members in their unit. This form is to be filled out by participants and parents or guardians and kept on file for easy reference.

Part B is required with parts A and C for any event that exceeds 72 consecutive hours, or when the nature of the activity is strenuous and demanding, such as a high-adventure trek. Service projects or work weekends may also fit this description. It is to be completed and signed by a certified and licensed health-care provider—physician (MD, DO), nurse practitioner, or physician's assistant as appropriate for your state. The level of activity ranges from what is normally expended at home or at school to strenuous activity such as hiking and backpacking. Other examples include tour camping, jamborees, and Wood Badge training courses. It is important to note that the height/weight limits must be strictly adhered to if the event will take the unit beyond a radius wherein emergency evacuation is more than 30 minutes by ground transportation, such as backpacking trips, high-adventure activities, and conservation projects in remote areas.

Risk Factors

Based on the vast experience of the medical community, the BSA has identified that the following risk factors may define your participation in various outdoor adventures.

For more information on medical risk factors, visit Scouting Safely on *www.scouting.org.*

Prescriptions

The taking of prescription medication is the responsibility of the individual taking the medication and/or that individual's parent or guardian. A leader, after obtaining all the necessary information, can agree to accept the responsibility of making sure a youth takes the necessary medication at the appropriate time, but BSA does not mandate or necessarily encourage the leader to do so. Also, if state laws are more limiting, they must be followed.

For frequently asked questions about this Annual Health and Medical Record, see Scouting Safely online at *http://www.scouting.org/scoutsource/HealthandSafety.aspx.* Information about the Health Insurance Portability and Accountability Act (HIPAA) may be found at *http://www.hipaa.org.*

Last name: DOB: Allergies: Emergency contact No.:

NAME TROOP CAMPSITE

Emergency contact No.: ______ Allergies: ______ DOB: ______ Last name: ______

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 (SEE PART C). 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 ______

MEDICAL HISTORY

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

Yes	No	Condition	Explain
		Asthma	
		Diabetes	
		Hypertension (high blood pressure)	
		Heart disease (i.e., CHF, CAD, MI)	
		Stroke/TIA	
		COPD	
		Ear/sinus problems	
		Muscular/skeletal condition	
		Menstrual problems (women only)	
		Psychiatric/psychological and emotional difficulties	
		Learning disorders (i.e., ADHD, ADD)	
		Bleeding disorders	
		Fainting spells	
		Thyroid disease	
		Kidney disease	
		Sickle cell disease	
		Seizures	
		Sleep disorders (i.e., sleep apnea)	
		GI problems (i.e., abdominal, digestive)	
		Surgery	
		Serious injury	
		Other	

Allergies or Reaction to:

Medication ______

Food, Plants, or Insect Bites ______

______

Immunizations:

The following are recommended by the BSA. Tetanus immunization 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
☐	☐	Tetanus ______
☐	☐	Pertussis ______
☐	☐	Diptheria ______
☐	☐	Measles ______
☐	☐	Mumps ______
☐	☐	Rubella ______
☐	☐	Polio ______
☐	☐	Chicken pox ______
☐	☐	Hepatitis A ______
☐	☐	Hepatitis B ______
☐	☐	Influenza ______
☐	☐	Other (i.e., HIB) ______

☐ Exemption to immunizations claimed.

(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 ______ ______ Distribution approved by: ______ / ______ Parent signature MD/DO, NP, or PA Signature Temporary ☐ Permanent ☐	Medication ______ Strength ______ Frequency ______ Approximate date started ______ Reason for medication ______ ______ Distribution approved by: ______ / ______ Parent signature MD/DO, NP, or PA Signature Temporary ☐ Permanent ☐	Medication ______ Strength ______ Frequency ______ Approximate date started ______ Reason for medication ______ ______ Distribution approved by: ______ / ______ Parent signature MD/DO, NP, or PA Signature Temporary ☐ Permanent ☐
Medication ______ Strength ______ Frequency ______ Approximate date started ______ Reason for medication ______ ______ Distribution approved by: ______ / ______ Parent signature MD/DO, NP, or PA Signature Temporary ☐ Permanent ☐	Medication ______ Strength ______ Frequency ______ Approximate date started ______ Reason for medication ______ ______ Distribution approved by: ______ / ______ Parent signature MD/DO, NP, or PA Signature Temporary ☐ Permanent ☐	Medication ______ Strength ______ Frequency ______ Approximate date started ______ Reason for medication ______ ______ Distribution approved by: ______ / ______ Parent signature MD/DO, NP, or PA Signature Temporary ☐ Permanent ☐

NOTE: Be sure to bring medications in the appropriate containers, and make sure that they are NOT expired, including inhalers and EpiPens. You SHOULD NOT STOP taking any maintenance medication.

Part B

PHYSICAL EXAMINATION

Height_____ Weight _____ % body fat_____ Meets height/weight limits ☐ Yes ☐ No
Blood pressure _____ Pulse _____

Individuals desiring to participate in any high-adventure activity or event in which emergency evacuation would take longer than 30 minutes by ground transportation will not be permitted to do so if they exceed the height/weight limits as documented in the table at the bottom of this page or if during a physical exam their health care provider determines that body fat percentage is outside the range of 10 to 31 percent for a woman or 2 to 25 percent for a man. Enforcing this limit is strongly encouraged for all other events, but it is not mandatory. (For healthy height/weight guidelines, visit www.cdc.gov.)

	Normal	Abnormal	Explain Any Abnormalities
Eyes			
Ears			
Nose			
Throat			
Lungs			
Heart			
Abdomen			
Genitalia			
Skin			
Emotional adjustment			

Range of Mobility	Normal	Abnormal	Explain Any Abnormalities
Knees (both)			
Ankles (both)			
Spine			

Other	Yes	No
Contacts		
Dentures		
Braces		
Inguinal hernia			Explain
Medical equipment (i.e., CPAP, oxygen)			

Tuberculosis (TB) skin test (if required by your state for BSA camp staff) ☐ Negative ☐ Positive

Allergies (to what agent, type of reaction, treatment): _____

I certify that I have, today, reviewed the health history, examined this person, and approve this individual for participation in:

☐ Hiking and camping ☐ Competitive activities ☐ Backpacking ☐ Swimming/water activities ☐ Climbing/rappelling
☐ Sports ☐ Horseback riding ☐ Scuba diving ☐ Mountain biking ☐ Challenge ("ropes") course
☐ Cold-weather activity (<10°F) ☐ Wilderness/backcountry treks

Specify restrictions (if none, so state) _____

Certified and licensed health-care providers recognized by the BSA to perform this exam include physicians (MD, DO), nurse practitioners, and physician's assistants.

To Health Care Provider: Restricted approval includes:
- ➔ Uncontrolled heart disease, asthma, or hypertension.
- ➔ Uncontrolled psychiatric disorders.
- ➔ Poorly controlled diabetes.
- ➔ Orthopedic injuries not cleared by a physician.
- ➔ Newly diagnosed seizure events (within 6 months).
- ➔ For scuba, use of medications to control diabetes, asthma, or seizures.

Provider printed name _____
Signature _____
Address _____
City, state, zip _____
Office phone _____
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

Height (inches)	Recommended Weight (lbs)	Allowable Exception	Maximum Acceptance
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.

Part C

Informed Consent and Hold Harmless/Release Agreement

I understand that participation in Scouting activities involves a certain degree of risk. I have carefully considered the risk involved and have given consent for myself and/or my child to participate in these activities. I understand that participation in these activities is entirely voluntary and requires participants to abide by applicable rules and standards of conduct. 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.

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.

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 to the adult in charge 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, including 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.

☐ Without restrictions.

☐ With special considerations or restrictions (list) _____

_____

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 the event: (You must designate at least one adult. Please include a telephone number.)

1. _____
2. _____
3. _____

Adults NOT authorized to take youth to and from the event:

1. _____
2. _____
3. _____

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.

Participant's name _____

Participant's signature _____

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

Date _____

Attach copy of insurance card (front and back) here. If required by your state, use the space provided here for notarization.

BOY SCOUTS OF AMERICA
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P.O. Box 152079
Irving, Texas 75015-2079
http://www.scouting.org

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Part C **Last name:** _____ **DOB:** _____

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