YOUTH HEALTH & MEDICAL RECORD---Camper – BS/CS Staff – BS/CS

Please sign all areas with this mark **

Parent/Guardian

The Boy Scouts of America requires that youth participating in any long-term camping experience (more than 72 hours)

a. MUST have a medical evaluation by a licensed medical provider within **36 months** of the camping experience.
b. MUST have a health history completed and signed by parent/guardian within **12 months** of the camping experience.

Name of Youth_____ Date of Birth_____ Unit #_____
Last Name First Name Initial

Youth Home Address_____ City_____ State_____

IN CASE OF EMERGENCY, NOTIFY:

Name of parent/guardian_____ AM Phone (_____)_____
Home address_____ PM Phone (_____)_____
City_____ State_____ Zip_____ Pager_____

IF PERSON NAMED ABOVE IS NOT AVAILABLE IN THE EVENT OF AN EMERGENCY, NOTIFY:

Name_____ Phone (____)_____ Relationship_____
Name_____ Phone (____)_____ Relationship_____

Medical Provider (Youth)_____ Provider Phone (_____)_____
Family Health/Accident Insurance_____ Policy No._____

STATE OF MICHIGAN REQUIRED AUTHORIZATIONS

The Michigan Department of Consumer and Industry Service pursuant to public Act 116 of 1973 and Administrative Rule 117.(2)(a) REQUIRES the following information.

Authorization is granted for the release of the aforementioned individual to adult employees, camp staff, and volunteers of the La Salle Council, Boy Scouts of America. In addition, to the parents and guardians signing this form, only those individuals listed below are authorized to remove the aforementioned individual from summer camp during their period of camping.

Please list spouse below if both parents have not signed the authorization below.

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

The Michigan Department of Consumer and Industry Services pursuant to Public Act 116 of 1973 and administrative Rule 127.1 (1) REQUIRES the following information:

The person herein described is in GOOD HEALTH and has all required immunizations. The information and health history contained herein is accurate and complete. Permission is granted for full participation in BSA programs and activities, subject to limitations noted herein. In the event I (we) cannot be reached in emergency. I (we) hereby grant permission to the medical provider selected by BSA representatives to authorize emergency medical/surgical treatment, routine non-surgical medical care, hospitalization, proper anesthesia and /or medication(s)/injection(s) for my (our) son (daughter). I (we) assume health & financial responsibility for the aforementioned individual.

** Date_____ Parent/Guardian Signature_____ Print_____

** Date_____ Parent/Guardian Signature_____ Print_____

** Date_____ Parent/Guardian Signature_____ Print_____

Current signature required EACH YEAR

YOUTH HEALTH HISTORY
(To be completed by Custodial Parent/Guardian)

IF YES IS CHECKED, PLEASE GIVE FULL DETAILS

***HAVE OR SUBJECT TO:** (Check if YES) **IF NONE: Check Here___**

_____ Heart Problems _____Asthma****** Uses an Inhaler No_____ Yes_____
_____ Seizure/Convulsion Disorder _____ Diabetes ***** Uses Insulin No_____ Yes_____
_____ Kidney Disorder _____Behavioral/Emotional Concerns_____
_____ Medication Allergies: List_____
_____ Food Allergies List_____
_____ Seasonal Allergies List_____
_____ Stinging Insect Reaction: Treatment_____
_____ Fainting Spells
_____ Bleeding Disorder
_____ Other Health Concern(s)_____

*** HAVE DIFFICULTY WITH:** (Check if YES) **IF NONE: Check Here____**

_____ Tires Easily _____ Muscle Fatigue _____ Ear Infections
_____ Breathing _____ Nose Bleed _____ Sinus Infections
_____ Stomach/Bowels _____ Sleeping _____ Athletes Foot
Explain:_____

***CURRENT HEALTH STATUS: (Check if YES)** **IF NONE: Check Here____**

_____ Currently under medical care {Explain:_____
_____ Currently taking any medications. {Complete CURRENT MEDICATION SECTION
_____ Serious illness/injury in past year Explain:_____
_____ Current ear, nose or throat infection. Explain:_____
_____ Current cold or seasonal allergy. Explain:_____
_____ Current behavioral/emotional concern. Explain:_____
_____ Other current health concerns. Explain:_____
_____Diet Restrictions. Explain:_____
_____ Activity restrictions. Explain:_____
_____ Wears contacts. _____ Wears dentures

*** IMMUNIZATION HISTORY (MUST indicate last inoculation date(s):)**
_____ tetanus Booster _____ Negative TB Test of Chest X-Ray **(Staff only)**
_____ Hepatitis B (optional) _____ Haemophilus Influenza B (optional)

The following immunizations are current and up to date:
MMR (measles, mumps, rubella)
DPT (diphtheria, pertussis, tetanus)
Polio, Smallpox, Varicella (Chicken Pox),BCG
And other_____

Special Diet needs or restrictions: _____

_____

** Custodial Parent/Guardian Signature_____ Date_____

** Custodial Parent/Guardian Signature_____ Date_____

** Custodial Parent/Guardian Signature_____ Date_____

Current year signature required

CURRENT MEDICATIONS (Prescription & Non-Prescription)

_____ My son (daughter) takes NO medications on a routine basis.

My son (daughter) takes the following medications on a regular basis.

Med # 1_____ Dosage_____ Times to be given_____
Reason for taking above medication:_____

Med # 2_____ Dosage_____ Times to be given_____
Reason for taking above medication:_____

Med # 3_____ Dosage_____ Times to be given_____
Reason for taking above medication:_____

Attach additional pages for more medications.

My son (daughter) takes the following medication during the school year but he/she does not take during the summer._____
_____
_____
_____

I (we) give permission for my (our) son (daughter) to receive the following over the counter medications as determined by an authorized BSA employee, camp staff or volunteer for purposes of First Aid Safety:

_____ NONE _____ Pain/Fever Reliever _____ Antihistamines _____ Anti-diarrheals
_____ Anti-acids _____ Cough/Cold meds _____ Topical Antibiotics & Anti-itch Ointments
_____ Other_____

** Custodial parent/guardian Signature:_____ Date:_____

TO BE COMPLETED BY A LICENSED MEDICAL PROVIDER

The Boy Scouts of America requires that youth participating in any long-term camping experience (more than 72 hours)

a. MUST have a medical evaluation by a licensed medical provider within **36 months** of the camping experience.
b. MUST have a health history completed by parent or guardian within **12 months** of the camping experience.

I certify that I have examined _____ on_____
Youth Name Date of Exam
And find him/her physically fit to participate in all Scouting activities EXCEPT as noted below. The aforementioned individual has all required immunizations as required by the State of Michigan.
HT._____ WT._____ B./P._____/_____ Pulse_____

Check 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	_____ Other (specify)

Comments:_____
Restrictions/Limitations:_____
Provider Signature:_____ Name/Phone_____

*********COMPLETE ONLY IF CUB/BOY SCOUT STAFF*********

The following information is REQUIRED by the Michigan Department of Consumer and Industry Services pursuant to public Act 116 of 1973 and Administrative Rule 109.(4).

Camp Staff Member's Name_____
Registered position in Council_____
Position in Camp_____

PLEASE INDICATE TRAINING RECEIVED AND DATE ISSUED:

Life Saving Merit Badge	_____	CPR BLS Certified	_____
BSA Life Guard	_____	Safe Swim Defense training	_____
ARC Basic Water Safety	_____	ARC 1st Aid Prof. Rescue	_____
ARC Advanced Swimmer	_____	ARC Life Guard Instructor	_____
ARC Water Safety Instructor	_____		
ARC First Aid	_____		
ARC Life Guard	_____		

Have you ever been convicted of anything other than a minor traffic violation? Yes____ No_____

If yes, please explain_____

The information contained in this form is correct to the best of my knowledge.

Date_____ Signed _____ , Staff Member

Date: _____ Signed _____, Parent if under 18

REFERENCES FOR CAMP STAFF (Must be completed prior to camp)

As a representative for the above named individual's unit, I recommend him/her to serve as staff at Camp Tamarack, Wood Lake Scout Reservation.

_____ _____ _____
Signature of registered adult from individual's unit Print Name Unit #

Knowing the good character of the above-identified individual, I recommend him/her to serve as a staff member at Camp Tamarack, Wood Lake Scout Reservation.

_____ _____
Character Reference Signature # 1 Print Name

Knowing the good character of the above-identified individual, I recommend him/her to serve as a staff member at Camp Tamarack, Wood Lake Scout Reservation.

_____ _____
Character Reference Signature # 2 Print Name