PERSONAL HEALTH AND MEDICAL RECORD FORM—Class 3

I. IDENTIFICATION

AGE____ SEX____ Date of Birth

NAME:____
Last Name First Name Initial Mo. Day Year

ADDRESS:____

CITY & STATE________________________________ ZIP________________

HEALTH/ACCIDENT INSURANCE____________________ POLICY NO.________________

IN AN EMERGENCY NOTIFY:

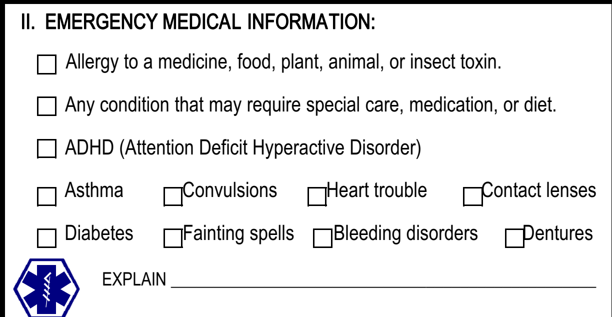
Name ____________________________ relationship

Address__________________________ (H) phone

City & State_____________________ (W) phone

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 competitions, 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 Wood Badge participants/staff regardless of age.



II. EMERGENCY MEDICAL INFORMATION:

- ☐ 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 ____

III. PARENTAL STATEMENT:

Has it ever been necessary to restrict applicant's activities for medical reasons? ☐ No ☐ Yes Does applicant take medicine regularly or have special care? ☐ No ☐ Yes If yes, explain below.

____

To the best of my knowledge, the information in sections I, II, III, IV and V, is accurate and complete. I request a licensed health-care practitioner to examine applicant, to give needed immunizations, 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 judgement of medical personnel dictates.

PARENT OR GUARDIAN X ____________________________
(Must sign if applicant is 18 or younger)

APPLICANT'S SIGNATURE X ____________________________

Date signed ____________________________

IV. IMMUNIZATIONS:

If disease, put "D" and year.

	Last Year Given
Tetanus	________
Diphtheria	________
Partussis	________
Measles	________
Rubella	________
Polio	________
Chicken Pox	________

Religious preference

V. LICENSED HEALTH-CARE PRACTITIONER;S EVALUATION AND ADVICE:

APPROVED FOR PARTICIPATION IN:

- ☐ Hiking and camping ☐ Competitive sports
- ☐ Water activities ☐ All activities

Specify exceptions ____

RECOMMENDATIONS: (Explain any restrictions OR limitations) ________________

____

____

Date ________________________

SIGNED X ____
*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.

NAME: ________________

UNIT: ________________

Bucks County Council, Boy Scouts of America
One Scout Way, Doylestown PA 18901

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) ________________
- 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 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
Serious illness	__	__	____	
Serious injury	__	__	____	
Deformity	__	__	____	
Surgery	__	__	____	
Skin, glands	__	__	____	
Ears, eyes	__	__	____	
Nose, sinus	__	__	____	
Teeth, tonsils	__	__	____	
Dentures	__	__	____	
Bridge	__	__	____	
Chest, lungs	__	__	____	
Heart	__	__	____	
Murmur	__	__	____	
Rheumatic fever	__	__	____	
Stomach, bowels	__	__	____	
Appendicitis	__	__	____	
Kidneys or urine	__	__	____	
Albumin	__	__	____	
Sugar	__	__	____	
Infection	__	__	____	
Bed-wetting	__	__	____	
Menstrual problems	__	__	____	
Hernia (rupture)	__	__	____	
Back, limbs, joints	__	__	____	
Sleepwalking	__	__	____	
Nervous condition	__	__	____	
Other (explain)	__	__	____	

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, adventure challenge or wilderness expedition (afoot 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 that applicant furnish complete medical history (VI) before exam.
- Review immunizations; for youth (18 or younger) tetanus and diphthena 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.

Date ____________________ VISION HEARING
Ht. __________ Wt. __________ Normal __________ Normal __________
B.P.______ / ______ Pulse ________ Glasses __________ Abnormal __________
Contacts __________

Check line if normal; circle if abnormal and give details below:

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

COMMENTS ____

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