Annual Health and Medical Record

Full Physical, Doctors Signature Required
(Valid for 12 calendar months)

Medical Information

The Boy Scouts of America requests as of January 1, 2010 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 B 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 A includes the parental informed consent and hold harmless/release agreement, a talent release statement, Lyme disease statement and permission to participate in shooting sports release. 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. All units should keep their own copy of their forms for any future camp visits; our camps are required to keep a copy of all completed forms that are turned in.

Part C is required with Parts A and B 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.

- Excessive body weight
- Heart disease
- Hypertension (high blood pressure)
- Diabetes
- Seizures
- Lack of appropriate immunizations
- Asthma
- Sleep disorders
- Allergies/anaphylaxis
- Muscular/skeletal injuries
- Psychiatric/psychological and emotional difficulties.

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 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.

This health form will need to be collected from everyone who attends one of our camps upon check in (youth and adult). Therefore, please make a copy of your forms to keep for your next camp visit throughout the coming year.

BOY SCOUTS OF AMERICA

This page needs to be completed by ALL for each camp you attend. Please retain a copy for your records.

Part A

RELEASE/STATEMENTS – each section requires an adult's signature

Lyme disease – Be wary, not worried, when enjoying the outdoors!

Lyme disease is becoming increasingly common in Minnesota, Wisconsin and other states. Lyme disease is spread by the bite of certain ticks. It is important for people who work or recreate outdoors to learn the facts about the disease and to prevent it. By taking some simple precautions and knowing the symptoms of the disease, we can continue to safely enjoy the pleasures and benefits of the outdoors. The links below will help Scouters stay safe while enjoying the woods. www.stopticks.org; www.lymediseaseassociation.com; and www.ilads.org I have read and understand this.

Signature of Parent or Legal Guardian: _____ Date:_____

Informed Consent and Hold Harmless/Release Agreement

I understand that participation in Scouting activities involved 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 examination findings, test results, and treatment provide 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)** _____

_____

Signature of Parent or Legal Guardian: _____ Date:_____

Permission to Participate in Shooting Sports for all Cub Scouts, Boy Scouts, Venturers and Explorers:

I, _____ (print your name) grant my consent to Northern Star Council and to its representatives including Range Officers and Instructors and others serving in these positions to furnish my child with BB guns or firearms and ammunition and provide instruction as to their use. I further certify that I am the parent with full parental rights or the legal guardian of this child. I understand that this document will be kept and maintained by the Northern Star Council or its representatives including Range Officers and Instructors. I further understand that any modification of this form will result in it s not being accepted by Northern Star Council, Range Officers and Instructors.

☐ **Yes my child has permission to participate in Shooting Sports without restrictions.**

☐ **No, my child does not have permission to participate in any Shooting Sports.**

Signature of Parent or Legal Guardian: _____ Date:_____

I have read and understand all the information shared in this form. 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 _____

Signature of Parent or Legal Guardian: _____ Date:_____

(if under the age of 18)

Participant's Last Name: _____ First Name:_____ DOB: _____ Unit #:____

This page needs to be completed by ALL for each camp you attend. Please retain a copy for your records.

Part B

HEALTH HISTORY

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. _____

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 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 _____
☐	☐	Chickenpox _____
☐	☐	Hepatitis A _____
☐	☐	Hepatitis B _____
☐	☐	Influenza _____
☐	☐	Other (i.e., HIB) _____

☐ Exemption to immunizations claimed.

(For more information about immunizations, as well as Immunization exemption form, see Scouting Safely on www.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 ☐
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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.

Revised March 2010

Last name: _____ DOB: _____ Allergies: _____ Unit # _____

This page needs to be completed if attending a camp that exceeds 72 hours. Please retain a copy for your records.

Part C
PHYSICAL EXAMINATION (Dr Signature Required)

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
Knee (both)			
Ankles (both)			
Spine			

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

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

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 and Human Services.

Last Name: _____ DOB: _____ Unit #:____