Longs Peak Council, B.S.A
Personal Health and Medical Record – Class 1 and 3

Instructions: By completing sections 1, 2, and 3, this form qualifies as a Class 1 medical history. A Class 1 medical history is a brief health history that does not require a physician's signature. By completing all sections (both pages); this form qualifies as a Class 2 or 3 medical record.

Who needs a Class 1? Anyone attending Cub Scout Day Camps, Cub Scout Resident Camps (Camp Nicol) and any overnight activities. (Less than 72 hours)

Who Needs a Class 3? Anyone attending a High Adventure Base or a Boy Scout Camp. (Longer than 72 hours)

1. Personal and Emergency Contact Information

Name:_____ Date of Birth: _____ Age: _____ Sex: _____

Address:_____ City, State: _____ Zip:_____

Name of Mother/Guardian/Spouse: _____ Address: _____ Phone #:_____

Place of Employment: _____ Address: _____ Phone #:_____

Name of Father/Guardian/Spouse: _____ Address: _____ Phone #: _____

Place of Employment: _____ Address: _____ Phone #: _____

If persons named above are not available in the event of an emergency, please contact:

Name: _____ Address: _____ Phone #: _____

Name: _____ Address: _____ Phone #: _____

Adults authorized to take youth from the event (include address and phone):

_____

_____

Persons NOT authorized to take youth from the event (include address and phone):

_____

_____

2. Health History / Information

Name of Primary Physician: _____
Primary Physician's Phone #: _____
Primary Physician's Address: _____
City, State: _____ Zip: _____
Name of Dentist/Orthodontist: _____
Dentist / Orthodontist Phone #: _____
Medical Insurance Provider:_____
Carrier's Name: _____
Policy or Group #: _____
Medicaid ID #: _____
Medications taken within the last 30 days:_____
_____
_____
Medications to be continued at event (with dosage):____
_____
_____
Other Special Instructions related to Medications:_____
_____
_____
Activities participant cannot participate in: _____
_____
_____

Immunizations: (Give date of last Inoculation)

Tetanus Toxoid _____ Measles/Mumps/Rubella _____ Polio _____

Diphtheria _____ Pertussis _____ Other _____

Is there history of the following(past or present)?

	Yes	No	Explain
Serious Illness			
Serious Injury			
Deformity			
Surgery			
Ears, Eyes			
Nose, Sinus			
Teeth, Tonsils			
Chest, Lungs			
Heart Murmur			
Rheumatic Fever			
Stomach, Bowels			
Appendicitis			
Kidney or Urine			
Albumin			
Sugar			
Infection			
Bed-Wetting			
Menstrual problems			
Hernia			
Back, Limbs, Joints			
Sleepwalking			
Nervous Condition			
Other (explain)			
Diet Restrictions			

3. Parent/Minor Signatures:

This health history is correct so far as I know, and the person herin described has permission to engage in all prescribed camp activities except as noted.
Emergency Authorization: I hereby give permission to the medical personnel selected by the camp officials to order x-rays, routine tests and treatment for me or my child, and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for me or my child as named above. Permission is also given to transport me or my child for medical assistance. This form may be photocopied for use at camp. I understand that I am responsible for payment of all medical treatments received from non-camp sources.

I also give permission for my child to go on trips away from camp premises, and to participate in all camp activities.

***Signature of parent or guardian (or participant if over 18): _____ Date: _____

***Signature of Minor: _____ Date: _____

4. Immunization History

Required Immunizations must be determined locally. Please record the date (month and year) of basic immunizations and most recent booster doses. If disease has occurred, indicate with a "D".

Vaccine	Dates of Immunizations/Boosters				
DTP/DTaP - Diptheria – Tetanus – Pertussis					
Td/DT - Tetanus-Diptheria					
OPV/IPV - Polio					
Hib - Haemophilus influenzae type b					
MMR - Measles - Mumps - Rubella					
HB - Hepatitis B					
Varicella - Chicken Pox					
Other					
Other					
Other					

To the best of my knowledge, the person named above has received the above immunizations.
Signed: _____ Title _____ Date _____
(Physician, nurse, or school health authority)

5. Medical Examination by Licensed Physician

Instructions to Licensed Health-Care Practioner:

This applicant will be participating in a strenuous activity that could 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.

Review complete medical history (part 2 on reverse side) furnished by applicant before beginning examination.

Review Immunization history (part 4 above) and assure that immunizations are complete and up-to-date.

Date of exam: _____
Height: _____ Weight: _____
Blood Pressure: _____ Pulse: _____
Vison: Normal_____ **Hearing**: Normal _____
Glasses_____ Abnormal _____
Contacts_____

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

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

Comments: _____
_____
_____
_____

Laboratory: Urinalysis (Dip Stick) Albumin_____ Sugar_____

6. Physician's Evaluation and Advice

Approved for participation in:
____Hiking ____Water Activities

____Competitive Sports _____All Activities
Specify Exceptions: _____
_____
Recommendations: (explain any restrictions or limitations)
_____

7. Authorization for Administration of Medication

BSA Health Officials are authorized to administer the following prescription medications:

Name of Medicine: _____
Date Prescribed: _____
Dosage and Directions for Use: _____
_____
_____
Name of Medicine: _____
Date Prescribed: _____
Dosage and Directions for Use: _____
_____
_____
Name of Medicine: _____
Date Prescribed: _____
Dosage and Directions for Use: _____
_____
_____
Name of Medicine: _____
Date Prescribed: _____
Dosage and Directions for Use: _____
_____

8. Authorization for Administration of Over-the-Counter Medications

BSA Health Officials are authorized to administer the following over-the-counter medications at the recommended doses:

___Tylenol ___Ibuprofen
___Benadryl ___Cough Drops
Other (please specify):_____
_____

Allergy to (please ***DO NOT*** give these medications):
_____
_____

9. Physician's Signature: (Certifying sections 5, 6, 7 & 8)

Licensed Physician Signature: _____ Date: _____

In addition to examinations conducted by medical doctors and doctors of osteopathy, examinations by registered nurse practitioners will be recognized.