LOST VALLEY SCOUT RESERVATION
PERSONAL HEALTH AND MEDICAL RECORD
CLASS 2 PHYSICAL FORM

Dear Parent or Guardian & Scout:

The Boy Scouts of America requires that all persons participating in a camping experience over 72 consecutive hours (3 days and nights) must have a medical evaluation by a physician licensed to practice medicine. For Lost Valley Scout Reservation, this evaluation must be within 24 months of the camping experience. In addition, a recent health history/medical summary must be completed within six months of the camping experience.

A written medical evaluation by a physician must accompany this form. Page 4 of this form is the evaluation that must be completed by a physician within the 24-month period. Page 2 and 3 of this form are the medical summary and health history update done by the participant within 3 months of the camping experience.

Check to be sure this form is complete:

[ ] Page 2 is completed **within 3 months of camp**. *If camp is in July, this form should be dated no earlier than April. A form dated in March is not current.*
[ ] Page 2, line 10, **signature** of parent/guardian attesting to the accuracy of the health history and medical summary.
[ ] Page 2, line 11, **signature** of parent/guardian gives consent to camp program. Box marked if the full program is allowed, program excluding rifle shooting, or limited program.
[ ] Page 3, personal information is complete, phone numbers are accurate.
[ ] Page 3, personal health/accident insurance carrier information is accurate. We recommend that all units carry secondary accident insurance for activities. Check with your unit leader. Unit accident insurance as well as personal insurance often is needed to provide adequate coverage for a major injury.
[ ] Page 3, personal information regarding emergency contact is accurate. Check phone numbers. List area code.
[ ] Page 3, **consent to treat in case of emergency is signed and dated by parent/guardian**. *A Scout cannot attend camp without this consent slip signed.*
[ ] Page 3, medical information is accurate and up to date, including immunizations. Be sure tetanus is within 10 years of attending camp. Be sure to list any specific allergies. During the summer, exertion and dust conditions can aggravate allergy and asthma conditions.
[ ] Page 4, **A medical evaluation by a physician licensed to practice medicine must be attached to this page. The evaluation must be within 24 months of the camp experience.** ***(Example: If attending camp July 1, 2008, the evaluation must be dated after July1, 2006. An evaluation dated on or before June 30, 2006 would not be current.)***

NOTE: This form is not to be used by adults over 40 years of age or those attending a national high adventure base or jamboree. Use form 4412A.

The camp may retain this form for their records. It may not be returned at the end of camp. A legible copy of all four pages of this form may be submitted instead of the original. If you have any questions about this personal health and medical record form, please contact the Camping Director; Orange County Council, Boy Scouts of America; 3590 Harbor Gateway North; Costa Mesa, California; 92626-1442.

1. Has participant had a medical evaluation **(physical examination)** with the **24 months** before the camping experience (summer camp)?
   [ ] YES-Proceed to question 2 and attach copy of evaluation to this form.
   [ ] NO-Schedule a physical examination with a physician licensed to practice medicine. The doctor should complete the medical evaluation on Page 4. A copy of this completed form should accompany the participant to camp. Proceed to question 2.

2. Has the participant had a **tetanus shot** in the last 10 years?
   [ ] YES-Indicate the date of the last immunization on Page 3 and proceed to question 3.
   [ ] NO-Schedule an appointment with a physician to receive a tetanus inoculation (or booster). Be sure to indicate the date of the tetanus shot on Page 3. Proceed to question 3.

3. Has the participant been **immunized against polio**?
   [ ] YES-Indicate the date of the immunization on Page 3 and proceed to question 4.
   [ ] NO-Although polio immunization is not required to attend camp, we strongly recommend that you consider such a series. Talk this over with your family physician. Proceed to question 4.

4. Have you been told by a physician that the participant should not participate in **strenuous activities**?
   [ ] NO-Proceed to question 5.
   [ ] YES-Please indicate on Page 3 what specific limitations should be imposed on activities in camp. Proceed to question 5.

5. Is a physician currently treating the participant?
   [ ] NO-Proceed to question 6.
   [ ] YES-Please provide a statement from your physician indicating what current treatment is being given. This may be in the form of a letter or use Page 4 of this form. Proceed to question 6.

6. Is the participant taking **prescribed medication** regularly?
   [ ] NO-Proceed to question 7.
   [ ] YES-Please provide a statement from your physician indicating present prescribed medication, including how and when it should be administered while in camp. Proceed to question 7.

7. Is the participant on a medically **prescribed meal plan**?
   [ ] NO-Proceed to question 8.
   [ ] YES-Please provide a copy of your diet to assist our commissary in preparing meals. This should be sent to camp three weeks prior to arrival with a note indicating name, troop number, and week in camp. Proceed to question 8.

8. Has the participant **lost consciousness** during physical activity or had a concussion due to a head injury?
   [ ] NO-Proceed to question 9.
   [ ] YES-Please provide a current statement from a physician licensed to practice medicine on the nature and extent of current symptoms. This may be a letter or use Page 4 of this form. Proceed to question 9.

9. Has participant had an **illness or injury** with the last **6 months** that limited activity for more than one week?
   [ ] NO-Fill out the lines below and continue to the next paragraph.
   [ ] YES-Schedule a visit with a physician for an updated medical evaluation. Fill out lines below and proceed to the next paragraph.

10. Camp program: Lost Valley camp programs include horseback riding, archery, swimming, boating, hiking, crafts, use of knife and ax, rock climbing, rappelling, team sports, COPE, rifle and shotgun shooting, and other activities. California Penal Code Section 12552 requires specific permission by parent/guardian giving consent for the use of firearms at camp. Your signature below grants consent to participate in the summer camp program. State any limitations below:

    [ ] Consent to full program including all activities listed above. [ ] Consent to full program excluding firearms.

    [ ] Consent to program with these limitations;_____

    Signature of parent/guardian or (camper if over 18 years of age): _____

11. The answers to these questions are correct to my best knowledge:

    Print full name of Parent/guardian: _____

    Signature of Parent/guardian: _____ Date: _____

NAME

TROOP

CAMPSITE

PERSONAL HEALTH AND MEDICAL RECORD

CLASS 1 AND CLASS 2

Class 1 (update annually for all participants). Activity: Day camp, overnight hike, or other programs not exceeding 72 hours, with level of activity similar to that of home or school. Medical care is readily available. Current personal health and medical summary (history) is attested by parents to be accurate.This form is filled out by all participants and is on file for easy reference.

Class 2 (required once every 24 months for all participants under 40 years of age). Activity: Resident camp or any other activity such as backpacking, tour camping, or recreational sports involving events lasting longer than 72 consecutive hours, with level of activity similar to that at home or school.Medical care is readily available.

Note: Some states require an **annual** precamp medical evaluation. Your BSA local council service center can advise you about the requirements for your state.

If your child has had a medical evaluation **(physical examination)** within the last 24 months, a copy of the results of this examination must be attached to the health history for all participants in a camping experience lasting longer than 72 consecutive hours. If a copy is not available, a physical examination (using the Class 2 section of this form) must be scheduled by a *licensed health-care practitioner.This medical evaluation (physical examination) also is required if your child is currently under medical care, takes a prescribed medication, requires a medically prescribed diet, has had an injury or illness during the past 6 months that limited activity for a week or more, has ever lost consciousness during physical activity, or has suffered a concussion from a head injury.

*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.

THIS FORM IS NOT TO BE USED BY ADULTS OVER 40, BY HIGH-ADVENTURE PARTICIPANTS (USE FORM NO. 34412A), OR FOR NATIONAL SCOUT JAMBOREE (USE FORM NSJ-34412-97).

CLASS 1 PERSONAL HEALTH AND MEDICAL HISTORY

(To be filled out annually by all participants)

To be filled out by parent, guardian, or adult participant. Please print in ink.

IDENTIFICATION

Name_____ Date of birth_____ Age_____ Sex_____

Name of parent or guardian_____ Telephone_____

Home address _____ City_____ State_____ Zip_____

Business address _____ City_____ State_____ Zip_____

If person named above is not available in the event of an emergency, notify

Name_____ Relationship_____ Telephone_____

Name_____ Relationship_____ Telephone_____

Name of personal physician_____ Telephone_____

Personal health/accident insurance carrier_____ Policy No._____

I give permission for full participation in BSA programs, subject to limitations noted herein.

In case of emergency, I understand every effort will be made to contact me (if participant is an adult, my spouse or next of kin). In the event I cannot be reached, I hereby give my permission to the licensed health-care practitioner selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child (or for me, if participant is an adult).

Date_____ Signature of parent/guardian or adult_____

Some hospitals require the parent/guardian signature to be notarized.Check with your BSA local council.

Check all items that apply, **past or present,** to your health history.Explain any "Yes"answers.

ALLERGIES: Food, medicines, insects, plants Yes ☐ No ☐ Explain: _____

GENERAL INFORMATION:	Yes	No		Yes	No		Yes	No
ADHD (Attention-Deficit Hyperactivity Disorder	☐	☐	Convulsions/seizures	☐	☐	Hemophilia	☐	☐
Asthma	☐	☐	Diabetes	☐	☐	High blood pressure	☐	☐
Cancer/leukemia	☐	☐	Heart trouble	☐	☐	Kidney disease	☐	☐

Explain:_____

Please list ALL medications taken in the 30 days **prior** to arrival at the Scouting activity where this form is to be used:_____

_____

List any medications to be taken at camp: _____

List any physical or behavioral conditions that may affect or limit full participation in swimming, backpacking, hiking long distances, or playing strenuous physical games: _____

List equipment needed such as wheelchair, braces, glasses, contact lenses, etc.: _____

Immunizations: (Give date of last inoculation.)

Tetanus toxoid_____	Measles_____	Polio_____
Diphtheria _____	Mumps _____	_____
Pertussis _____	Rubella _____	_____

CLASS 2 MEDICAL EVALUATION

(Read additional requirements outlined on front of form.)

Name_____ Age_____

NOTE TO LICENSED HEALTH-CARE PRACTITIONERS*: The person being evaluated will be attending one or more weeks of camp that may include sleeping on the ground and participating in strenuous activities such as hiking, boating, and vigorous group games.Please review the health history with the participant for any interim changes. **Explain any "abnormal" evaluations.**

PHYSICAL EXAMINATION (To be filled out by a licensed health-care practitioner*)

Height_____ Weight_____ BP_____/_____ Pulse_____

VISION: Normal _____ Glasses _____ Contacts_____

HEARING: Normal _____ Abnormal _____ Explain_____

Check box:	N	Abn		N	Abn		N	Abn
Growth development	☐	☐	Teeth	☐	☐	Genitalia	☐	☐
Skin	☐	☐	Cardiopulmonary system	☐	☐	Musculoskeletal	☐	☐
HEENT	☐	☐	Hernia	☐	☐	Neurobehavioral	☐	☐

Explain:_____

Limitations

Activity restrictions _____

Diet restrictions_____

Signature_____ Date_____

Licensed health-care practitioner*

Address_____ Phone_____

City, State, Zip _____

***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.**

INTERVAL RECORD	SCREENING EXAMINATION	
Date, Time, Place, Etc.	(Findings, diagnoses, treatment, instructions, disposition, etc.)	By

#34414A

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PHOTOCOPING THIS FORM IS PERMITTED.

34414A
1999 Printing

NAME

TROOP

CAMPSITE