

# Annual Health and Medical Record

(Valid for 12 calendar months)

## Medical Information

The Boy Scouts of America recommends 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 C** are to be completed annual **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 C also includes the parental informed consent and hold harmless/release agreement as well as a talent release statement. 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.

**Part B** is required with parts A and C for any event that exceeds 72 consecutive hours, a resident camp setting, or when the nature of the activity is strenuous and demanding, such as service projects, work weekends, or high adventure treks. 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 chart 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.

## Rick Factors

Based on the vast experience of the medical community, the BSA as 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](http://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 the necessary information, can agree to accept the responsibility of making sure a youth takes the necessary medication at the appropriate time, but the BSA does not mandate or necessarily encourage the leader to do so. Also, if the state laws are more limiting, the must be followed.



BOY SCOUTS OF AMERICA

# Annual BSA Health and Medical Record

## Part A

### GENERAL INFORMATION

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. \_\_\_\_\_

**ATTACH A PHOTOCOPY OF BOTH SIDES OF INSURANCE CARD (SEE PART C).  
 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 ever 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 enter the year received.

Yes	No	Date
<input type="checkbox"/>	<input type="checkbox"/>	Tetanus _____
<input type="checkbox"/>	<input type="checkbox"/>	Pertussis _____
<input type="checkbox"/>	<input type="checkbox"/>	Diphtheria _____
<input type="checkbox"/>	<input type="checkbox"/>	Measles _____
<input type="checkbox"/>	<input type="checkbox"/>	Mumps _____
<input type="checkbox"/>	<input type="checkbox"/>	Rubella _____
<input type="checkbox"/>	<input type="checkbox"/>	Polio _____
<input type="checkbox"/>	<input type="checkbox"/>	Chicken pox _____
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A _____
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B _____
<input type="checkbox"/>	<input type="checkbox"/>	Influenza _____

Exemption to immunizations claimed.

(For more information about immunizations, as well as the immunization exemption form, see Scouting Safely on [Scouting.org](http://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 _____ Reason for medication _____ Approximate date started _____ Temporary <input type="checkbox"/> Permanent <input type="checkbox"/>	Medication _____ Strength _____ Frequency _____ Reason for medication _____ Approximate date started _____ Temporary <input type="checkbox"/> Permanent <input type="checkbox"/>	Medication _____ Strength _____ Frequency _____ Reason for medication _____ Approximate date started _____ Temporary <input type="checkbox"/> Permanent <input type="checkbox"/>
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**NOTE:** Be sure to bring medications in appropriate containers, and make sure that they are **NOT** expired, including inhalers and EpiPens. You **SHOULD NOT STOP** taking any maintenance medication

Emergency contact No.:

Allergies:

DOB:

Last name:

**Part B**

**PHYSICAL EXAMINATION**

Height \_\_\_\_\_ Weight \_\_\_\_\_ Meets height/weight limits  Yes  No Blood pressure \_\_\_\_\_ Pulse \_\_\_\_\_

Individuals desiring to participate in any high-adventure activity or events in which emergency evacuation would take longer than 30 minutes by ground transportation will not be permitted to do so if they exceed the weight limit as documented at the bottom of this page. Enforcing the height/weight limit is strongly encouraged for all other events, but is not mandatory. (For healthy height/weight guidelines, visit [www.cdc.gov](http://www.cdc.gov).)

	Normal	Abnormal	Explain Any Abnormalities	Range of Mobility	Normal	Abnormal	Explain Any Abnormalities
Eyes				Knees (both)			
Ears				Ankles (both)			
Nose				Spine			
Throat							
Lungs				Other	Yes	No	
Heart				Contacts			
Abdomen				Dentures			
Genitalia				Braces			
Skin				Inguinal hernia			Explain
Emotional adjustment				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     Competitive activities     Backpacking     Swimming/water activities     Climbing/rappelling
- Sports     Horseback riding     Scuba diving     Mountain biking     Challenge ("ropes") course
- Cold-weather activity (<10 °F)     Wilderness/backcountry treks

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 & Human Services.

**Part B**

Last name: \_\_\_\_\_ DOB: \_\_\_\_\_

Part C

Parental Informed Consent and Hold Harmless/Release Agreement

I understand that participation in Scouting activities involves a certain degree of risk. I have carefully considered the risk involved and have given consent for myself 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 provided 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)

Talent Release Form

I hereby assign and grant to the local council and the Boy Scouts of America the right and permission to use and publish the photographs/film/videotapes/electronic representations and/or sound recordings made of me or my child by the Boy Scouts of America, and I hereby release the Boy Scouts of America from any and all liability from such use and publication.

I hereby authorize the reproduction, sale, copyright, exhibit, broadcast, electronic storage, and/or distribution of said photographs/film/videotapes/electronic representations and/or sound recordings without limitation at the discretion of the Boy Scouts of America, and I specifically waive any right to any compensation I may have for any of the foregoing.

- Yes No

I understand that, 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

Parent/guardian's signature (if under the age of 18)

Date

Attach copy of insurance card (front and back) here.

## Summer Camp Medications Permission Form

(To Be Completed and Submitted With Medical Form)

Last: \_\_\_\_\_ First: \_\_\_\_\_ Unit: \_\_\_\_\_  
 Address: \_\_\_\_\_ Unit Town: \_\_\_\_\_  
 Phone: \_\_\_\_\_ DOB: \_\_\_\_\_ Weight: \_\_\_\_\_

Parent/Guardian Approval: I request that my son/daughter receive the over the counter and prescription medications as indicated my child's Health Care Provider and request self administration of prescription drugs if approved.

Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_\_

Oral Agents	Dosage	Indication and Schedule	Camper Health Care Provider		Comments
			Approval	Initials	
Benadryl (Diphenhydramine)	<90# 25 mg >=90# 50 mg	Allergic Reaction/Hay Fever every six hrs as needed for 24 hours	yes no		
Immodium	initial 4 tsp repeat 2 tsp	Diarhea as needed for watery stool limit 8 tsp	yes no		
Maalox	30 cc	Indigestion/Heartburn once	yes no		
Milk of Magnesia	30 cc	Constipation daily twice as needed	yes no		
Robitussin	per label instructions	Colds every six hours as needed	yes no		
Tylenol (Acetaminophen)	15 mg/kg (below)	Fever, Headache, Pain Control, Toothache every 4 hours as needed	yes no		
<b>Topical Agents</b>					
Bacitracin	per label instructions	Wound Care twice daily and as needed	yes no		
Caladryl	per label instructions	Insect Bites/Poison Ivy twice daily and as needed	yes no		
Desinex Powder	per label instructions	Athletes Foot twice daily and as needed	yes no		
Lotrimin	per label instructions	Jock Itch three times daily	yes no		

Tylenol Dosing				
wt (pounds)	50-75	75-95	95-150	>150
Dose	325 mg	500 mg	650 mg	1000 mg

Prescription Medication	Dosage and Route	Indication and Schedule	Camper Health Care Provider Approval		Comments
			Self Administration	Initials	
			yes no		
			yes no		
			yes no		
			yes no		

Health Care Provider: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ License #: \_\_\_\_\_  
 Signature: \_\_\_\_\_ :Date: \_\_\_\_\_