Requirements for BSA Annual Health and Medical Records for Use at Resident Camps

The summer of 2010 was the first year using the BSA Annual Health and Medical Record. Experience has indicated that there are several essential areas that are often overlooked on this form, omissions that may render the form inadequate for camp. Below please find a checklist of three items which, if improperly completed, could make the form useless:

- ☐ Part A, Medications - One block is to be filled out for each prescribed medication with the signature of both the doctor and the parent at the bottom of the page. The State of Connecticut requires both signatures for administration of medications.
- ☐ Part C, Examiner's Certification - Doctor's signature and other provider information must be complete.
- ☐ Date of the physical - Under the doctor's information and signature, the physical form MUST be dated. If there is no date, there is no way to verify that the physical was conducted within 12 calendar months of the end date of the person's camp attendance.

Omission of any of these items nullifies the health form.

Note: Please make sure that the person's name is on every page of the health and medical record. This is especially important if you are faxing the form as pages do not always remain in proper order. A page without a name is not valid.

Annual BSA Health and Medical Record
Part A
GENERAL INFORMATION

High-adventure base participants:
Expedition/crew No.: _____
or staff position: _____

Session(s) attending (circle):
Sequassen – week 1 2 3 4 5 6 7
Deer Lake – session 1 2 3 4 5 6 7
or Family Weekend

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. 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 _____

HEALTH HISTORY

Are you now, or have you ever been treated for any of the following:

Yes	No	Condition	Explain
		Asthma Last attack: _____	
		Diabetes Last HbA1c: _____	
		Hypertension (high blood pressure)	
		Heart disease (e.g., CHF, CAD, MI)	
		Stroke/TIA	
		Lung/respiratory disease	
		Ear/sinus problems	
		Muscular/skeletal condition	
		Menstrual problems (women only)	
		Psychiatric/psychological and emotional difficulties	
		Behavioral disorders (e.g., ADD, ADHD, Asperger syndrome, autism)	
		Bleeding disorders	
		Fainting spells	
		Thyroid disease	
		Kidney disease	
		Sickle cell disease	
		Seizures Last seizure: _____	
		Sleep disorders (e.g., sleep apnea)	Use CPAP: Yes ☐ No ☐
		Abdominal/digestive problems	
		Surgery	
		Serious injury	
		Other	

Allergies or Reaction to:

Medication _____
Food, Plants, or Insect Bites _____
_____

Immunizations:

The following are recommended by the BSA. **Tetanus immunization is required and 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 _____
☐	☐	Diphtheria _____
☐	☐	Measles _____
☐	☐	Mumps _____
☐	☐	Rubella _____
☐	☐	Polio _____
☐	☐	Chicken pox _____
☐	☐	Hepatitis A _____
☐	☐	Hepatitis B _____
☐	☐	Influenza _____
☐	☐	Other (i.e., HIB) _____

☐ Exemption to immunizations claimed (form required).

(For more information about immunizations, as well as the immunization exemption form, see Scouting Safely on 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 _____ _____	Medication _____ Strength _____ Frequency _____ Approximate date started _____ Reason for medication _____ _____	Medication _____ Strength _____ Frequency _____ Approximate date started _____ Reason for medication _____ _____
Medication _____ Strength _____ Frequency _____ Approximate date started _____ Reason for medication _____ _____	Medication _____ Strength _____ Frequency _____ Approximate date started _____ Reason for medication _____ _____	Medication _____ Strength _____ Frequency _____ Approximate date started _____ Reason for medication _____ _____

Administration of the above medications is approved by (if required by your state): _____/_____
Parent/guardian signature and/or MD/DO, NP, or PA signature

Be sure to bring medications in sufficient quantities and the original containers. Make sure that they are NOT expired, including inhalers and EpiPens. You SHOULD NOT STOP taking any maintenance medication.

Last Name: _____ First Name: _____ Unit: (circle) Troop/Pack/Crew # _____ Campsite: _____

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Part B

High-adventure base participants:
Expedition/crew No.: _____
or staff position: _____

INFORMED CONSENT AND HOLD HARMLESS/RELEASE AGREEMENT

I understand that participation in Scouting activities involves a certain degree of risk and can be physically, mentally, and emotionally demanding. I also understand that participation in these activities is entirely voluntary and requires participants to abide by applicable rules and standards of conduct.

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 protected health information to the adult in charge, camp medical staff, camp management, and/or any physician or health care provider involved in providing medical care to the participant. Protected Health Information/Confidential Health Information (PHI/CHI) under the Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. §§160.103, 164.501, etc. seq., as amended from time to time, includes 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.

I have carefully considered the risk involved and give consent for myself and/or my child to participate in these activities. 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.

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.

☐ Without restrictions.

☐ With special considerations or restrictions (list) _____

_____

TALENT RELEASE AGREEMENT

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 at all Scouting activities, and I hereby 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 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

ADULTS AUTHORIZED TO TAKE YOUTH TO AND FROM EVENTS:

You must designate at least one adult. Please include a telephone number.

1. Name _____ Telephone _____
2. Name _____ Telephone _____
3. Name _____ Telephone _____

Adults NOT authorized to take youth to and from events:

1. Name _____
2. Name _____
3. Name _____

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.

If I am participating at Philmont, Philmont Training Center, Northern Tier, or Florida Sea Base: I have also read and understand the risk advisories explained in Part D, *including height and weight requirements and restrictions*, and understand that the participant will not be allowed to participate in applicable high-adventure programs if those requirements are not met. The participant has permission to engage in all high-adventure activities described, except as specifically noted by me or the health-care provider.

Participant's name _____

Participant's signature _____ Date _____

Parent/guardian's signature _____ Date _____
(if participant is under the age of 18)

Second parent/guardian signature _____ Date _____
(if required; for example, CA)

This Annual Health and Medical Record is valid for 12 calendar months.

High-adventure base participants:
Expedition/crew No.: _____
or staff position: _____

Part C

TO THE EXAMINING HEALTH-CARE PROVIDER (Certified and licensed physicians [MD, DO], nurse practitioners, and physician's assistants)

You are being asked to certify that this individual has no contraindication for participation in a Scouting experience. For individuals who will be attending a high-adventure program at one of the national high-adventure bases, please refer to Part D for additional information.

(Part D was made available to me. ❑ Yes ❑ No)

PHYSICAL EXAMINATION

Height (inches) _____ Weight (pounds)_____ Maximum weight for height _____ Meets height/weight limits ☐ Yes ☐ No
Blood pressure _____ Pulse _____ Percent body fat (optional)_____

If you exceed the maximum weight for height as explained on this page and your planned high-adventure activity will take you more than 30 minutes away from an emergency vehicle–accessible roadway, you **will not** be allowed to participate. At the discretion of the medical advisors of the event and/or camp, participation of an individual exceeding the maximum weight for height may be allowed if the body fat percentage measured by the health-care provider is determined to be 20 percent or less for a female or 15 percent or less for a male. (Philmont requires a water-displacement test to be used for this determination.) Please call the event leader and/or camp if you have any questions. Enforcing the height/weight guidelines is strongly encouraged for all other events.

	Normal	Abnormal	Explain Any Abnormalities
Eyes			
Ears			
Nose			
Throat			
Lungs			
Neurological			
Heart			
Abdomen			
Genitalia			
Skin			
Emotional adjustment			

Range of Mobility	Normal	Abnormal	Explain Any Abnormalities
Knees (both)			
Ankles (both)			
Spine			

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

Tuberculosis (TB) skin test (if required by your state for BSA camp staff) ☐ Negative ☐ Positive

Allergies (to what agent, type of reaction, treatment): _____

Restrictions (if none, so state) _____

EXAMINER'S CERTIFICATION

I certify that I have reviewed the health history and examined this person and find no contraindications for participation in a Scouting experience. This participant (with noted restrictions above)

True	False	
☐	☐	Meets height/weight requirements
☐	☐	Does not have uncontrolled heart disease, asthma, or hypertension
☐	☐	Has not had an orthopedic injury, musculoskeletal problems, or orthopedic surgery in the last six months or possesses a letter of clearance from their orthopedic surgeon or treating physician
☐	☐	Has no uncontrolled psychiatric disorders
☐	☐	Has had no seizures in the last year
☐	☐	Does not have poorly controlled diabetes
☐	☐	If less than 18 years of age and planning to scuba dive, does not have diabetes, asthma, or seizures

Provider printed name _____
Address _____
City, state, zip _____
Office phone _____
Signature _____
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
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.

DO NOT WRITE IN THIS BOX

REVIEW FOR CAMP OR SPECIAL ACTIVITY
Reviewed by _____ Date _____
Further approval required ❑ Yes ❑ No Reason _____
By _____ Date _____

Part C **Full name:** _____ **DOB:** _____

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Connecticut Yankee Council -- Addendum to Annual BSA Health and Medical Record

This addendum to the Annual BSA Health and Medical Record for youths under 18 years of age is required to meet Connecticut Department of Health requirements. Please read and sign the form at the bottom of the page.

If you do not wish to have any of the following over-the-counter medications administered, please cross out and initial. If there is a continued need for multiple dosage of over-the-counter medication, the Health Officer will be in contact with you about having a discussion with the Scout's primary medical provider for treatment options.

- I give my permission for the camp Health Officer to administer over-the-counter medications as directed by the Camp Physician in the Camp Standing Medical Care and Treatment Procedures. The Connecticut Yankee Council's policy on medications at Scout camp has been written to comply with the National Standards of the Boy Scouts of America and the State of Connecticut Health Dept.

  Over the counter medications may include:
  - Sunscreen, topically, as needed for sun exposure
  - Bug repellant, topically, as needed every 2-4 hrs.
  - Robitussin (Guifenesin), by mouth, per weight/age dosing for cough as needed every 6 hrs.
  - Benadryl (Diphenhydramine), by mouth, per weight/age dosing for rash/itch/anaphylactic reaction, as needed, every 4-6 hrs.
  - Maalox, by mouth, per weight/age dosing for upset stomach, as needed or Tums, by mouth, per weight/age dosing for upset stomach, as needed
  - Kaopectate, by mouth, per weight/age dosing for diarrhea, as needed every 4 hrs *(NOT more than 2consecutive doses)*
  - Milk of Magnesia, by mouth, per weight/age dosing for constipation, as needed every 6 hrs *(NOT more than 2 consecutive doses)*
  - Tylenol (Acetaminophen), by mouth, per weight/age dosing for pain, as needed every 4-6 hrs
  - Motrin (Ibuprofen), by mouth, per weight/age dosing for pain as needed every 6-8 hrs
  - Throat lozenges, by mouth, 1 tab for sore throat every 2-4 hrs, as needed
  - Bacitracin, topically, for wound care/infection prevention, as needed
  - Calamine Lotion, topically, for itch/contact dermatitis, as needed, every 1 hr.

This section must be signed to indicate acceptance of conditions above:

Signature of parent/guardian: _____

Name (print): _____

Relationship: _____ Date Signed: _____

Please double check that all signatures, parent/guardian/authorized health care provider, are entered as appropriate on all pages of the health form.

Full Name: _____ **DOB:** _____ **Unit:** _____ **Campsite:** _____