

PERSONAL HEALTH AND MEDICAL RECORD FORM—Class 3

I. IDENTIFICATION Age _____ Sex _____ Date of Birth* _____

Name _____
 Last name First name Initial Mo. Day Year

Address _____

City & State _____ Zip _____

Health/Accident insurance _____ Policy no. _____

IN AN EMERGENCY NOTIFY:

Name _____ Relationship _____

Address _____ Home phone _____
 City & State _____ Business phone _____
 Personal Physician _____ Phone _____

BOY SCOUTS OF AMERICA

All Class 3 activities require a health examination within the past 12 months by a licensed health-care practitioner.* This includes youth and adult members participating in high-adventure activities, athletic competition, and world jamborees. Annually, this form is to be used by adults over 40 for all activities requiring a physical examination and applies to *all* Wood Badge participants/staff regardless of age.

II. EMERGENCY MEDICAL INFORMATION

Has or is subject to (check and give details):

Allergy to a medicine, food†, plant, animal, or insect toxin _____

Any condition that may require special care, medication, or diet _____

ADHD (Attention Deficit Hyperactive Disorder) _____

Asthma _____ Convulsions _____ Heart trouble _____ Contact lenses _____

Diabetes† _____ Fainting spells _____ Bleeding disorders _____ Dentures _____

EXPLAIN _____

PLEASE TYPE OR PRINT.

NAME _____

UNIT _____

NOTE: Keep original form for your personal record. Make reproductions for agency use. Be sure information and signatures are legible on reproduced copies. This upper section may be reproduced and carried with you for emergency identification and care.

III. PARENTAL STATEMENT

Has it ever been necessary to restrict applicant's activities for medical reasons? No Yes Does applicant take medicine regularly or have special care? No Yes If yes, explain. _____

To the best of my knowledge, the information in sections I, II, III, IV, and VI is accurate and complete. I request a licensed health-care practitioner to examine applicant, to give needed immunization, and to furnish requested information to other agencies as needed. I give my permission for full participation in BSA programs, subject to limitations noted herein. In the event of illness or accident in the course of such activity, I request that measures be instituted without delay as judgment of medical personnel dictates.

Parent or guardian _____
 (Must sign if applicant is 18 or younger)

Applicant's signature _____

Date signed _____

IV. IMMUNIZATIONS

If disease, put "D" and year. Last year given _____

Tetanus _____

Diphtheria _____

Pertussis _____

Measles _____

Mumps _____

Rubella _____

Polio _____

Chicken Pox _____

Religious preference _____

V. LICENSED HEALTH-CARE PRACTITIONER'S EVALUATION AND ADVICE

Approved for participation in:

Hiking and camping Water activities

Competitive sports All activities

Specify exceptions _____

Recommendations (explain any restrictions OR limitations): _____

Signed _____ Date _____
 *Licensed health-care practitioner

*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.

VI. MEDICAL HISTORY

Parent (or applicant if 18 or older): Fill in sections I, II, III, IV, and VI *before seeing a licensed health-care practitioner.* Check immunizations to be given at this time. Be sure to include any emergency information and restrictions or special care that should be observed. Especially be sure to record any injuries, illnesses, surgery, or significant changes in condition of health of applicant since last complete examination.

- Date of most recent complete physical examination _____
- Are you aware of any current health problems? No Yes
- Now under medical care or taking medicines? No Yes
- Has there been any surgery, injury, illness, allergy, or change in health status since last complete physical examination? No Yes

Give dates and full details below for any "yes" answers.

IS THERE DISEASE OF (OR PAST OR PRESENT HISTORY OF):

	No	Yes	Year	Details/Medicines
Serious illness	_____	_____	_____	_____
Serious injury	_____	_____	_____	_____
Deformity	_____	_____	_____	_____
Surgery	_____	_____	_____	_____
Skin, glands	_____	_____	_____	_____
Ears, eyes	_____	_____	_____	_____
Nose, sinus	_____	_____	_____	_____
Teeth, tonsils	_____	_____	_____	_____
Dentures	_____	_____	_____	_____
Bridge	_____	_____	_____	_____
Chest, lungs	_____	_____	_____	_____
Heart	_____	_____	_____	_____
Murmur	_____	_____	_____	_____
Rheumatic fever	_____	_____	_____	_____
Stomach, bowels	_____	_____	_____	_____
Appendicitis	_____	_____	_____	_____
Kidneys or urine	_____	_____	_____	_____
Albumin	_____	_____	_____	_____
Sugar	_____	_____	_____	_____
Infection	_____	_____	_____	_____
Bed-wetting	_____	_____	_____	_____
Menstrual problems	_____	_____	_____	_____
Hernia (rupture)	_____	_____	_____	_____
Back, limbs, joints	_____	_____	_____	_____
Sleepwalking	_____	_____	_____	_____
Nervous condition	_____	_____	_____	_____
Other (explain)	_____	_____	_____	_____

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

VII. HEALTH EXAMINATION

Licensed Health-Care Practitioner:

The applicant will be participating in a strenuous activity that will include one or more of the following conditions: athletic competition, adventure challenge or wilderness expedition (afloat or onfoot) that may include high altitude, extreme weather conditions, cold water, exposure, fatigue, and/or remote conditions where readily available medical care cannot be assured.

- Please insist applicant furnish complete medical history (VI) before exam.
- Review immunizations; for youth (18 or younger) tetanus and diphtheria toxoids, measles, mumps, and rubella vaccines, and trivalent oral polio vaccine are required; youths and adults must have had tetanus booster within 10 years. A measles booster is recommended at age 12.
- After completing section VII, summarize any restrictions and/or recommendations in sections II and V, above, and sign.

Date _____ VISION: _____ HEARING: _____
 Normal _____ Normal _____

Ht. _____ Wt. _____ Glasses _____ Abnormal _____
 B.P. _____ / _____ Pulse _____ Contacts _____

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

Growth, development Teeth, tonsils Genitourinary

Skin, glands, hair Respiratory Skeletomuscular

Head, neck, thyroid Cardiovascular Neuropsychiatric

Eyes, ears, nose Abdomen, hernia, rings Other (specify) _____

COMMENTS _____

FOR THOSE ATTENDING PHILMONT OR NATIONAL HIGH-ADVENTURE BASES:

* The minimum age for all participants is 13 by January 1 of the year of participation, or have completed the seventh grade. No exceptions.

† Trail food is by necessity a high-carbohydrate, high-calorie diet. It is high in wheat, milk products, sugar, corn syrup, and artificial coloring/flavoring. Dinner meals contain meat. If these food products cause a problem in your diet, you need to bring appropriate substitutions with you and so advise base personnel.

Note: Licensed health-care practitioners representing high-adventure bases reserve the right to deny access to the trails or other program activity on the basis of a medical evaluation performed at the base after arrival.

REVIEW FOR CAMP OR SPECIAL ACTIVITY

DATE	AGENCY AND ACTIVITY	BY	"OK"	PHYSICIAN RECHECK NEEDED	RESULTS OF RECHECK	INITIAL

INTERVAL RECORD

(CAMP, CAMPOREE, TOURNAMENT, TRAVEL, ETC.)

DATE, TIME, PLACE, ETC.	FINDINGS, DIAGNOSES, TREATMENT, INSTRUCTIONS, DISPOSITION, ETC.	BY: