PERSONAL HEALTH AND MEDICAL RECORD FORM—Class 3

I. IDENTIFICATION Age_____ Sex_____ Date of Birth* (Mo. Day Year)

Name_____ (Last name First name Initial)

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

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 _____

Updated _____ Signed _____
Parent or guardian

Updated _____ Signed _____
Parent or guardian

IV. IMMUNIZATIONS

If disease, put "D" and year.

	Last year given
Tetanus	
Diphtheria	
Pertussis	
Measles	
Mumps	
Rubella	
Polio	
Chicken Pox	

Religious preference

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 40 years of age or older 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 _____

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): _____

_____

_____

Date _____

Signed _____
*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.

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.

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 (month and year) _____ 20____
- 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 (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.

- 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: Normal _____ Glasses _____ Contacts _____ HEARING: Normal _____ Abnormal _____

Ht. _____ Wt. _____

B.P._____ / _____ Pulse_____

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.

CERTIFICATE OF IMMUNIZATION

105 CMR 430.152

Written documentation of immunization or alternative proof of immunity shall be required for all campers, adults, and staff as follows:

FIRST NAME_____LAST NAME _____

STREET ADDRESS_____

CITY/STATE/ZIP_____ DATE OF BIRTH _____/_____/_____

PARENT/GUARDIAN_____ PHONE _____

CAMP AND SESSION(S) ATTENDING _____

For Campers and Staff under 18 Years Old

1) ***Measles, Mumps and Rubella (MMR) Vaccine:*** At least one dose of MMR vaccine(s) must be administered at or after 12 months of age or there must be laboratory evidence of immunity. A second dose of live, measles containing vaccine is required for all campers and staff.
   Both Doses of measles vaccine must be given at least one month apart, and must be given at or after 12 months of age, or laboratory evidence of immunity.
2) ***Polio Vaccine:*** At least three doses of either trivalent oral polio vaccine (OPV) or enhanced potency inactivated polio vaccine (e-IPV) are required. If a mixed schedule of polio vaccine is given (IPV and OPV) a total of four doses is required
3) ***Diphtheria and Tetanus Toxoids and Pertussis Vaccine:*** At least four doses of DtaP/DTP/DT/tD are required (the Pertussis component is not given to anyone seven years of age or older). A booster dose of tetanus/diphtheria, adult type toxoid (Td) is required if more than ten years have elapsed since the last dose.
4) ***Hepatitis B:*** For all children born on or after January 1, 1992, three doses of Hepatitis B vaccine are required.

For Staff and Adults 18 Years of Age or Older

1) ***Measles Vaccine:*** Unless born before 1957, two doses of live, measles containing vaccine administered at or after 12 months of age (at least one month apart) are required, or there must be laboratory evidence of immunity to measles.
2) ***Mumps Vaccine:*** Unless born before 1957, at least one dose of mumps vaccine administered at or after 12 months of age is required, or there must be laboratory proof of immunity to mumps.
3) ***Rubella Vaccine:*** at least one dose of rubella vaccine administered at or after 12 months of age is required, or there must be laboratory proof of immunity to rubella.
4) ***Diphtheria and Tetanus Toxoids:*** At least three doses of DT/dT are required. A booster dose of tetanus/diphtheria, adult type toxoid (dT) is required if more than ten years have elapsed since the last dose.

Physical Examinations or Immunizations Excepted (105 CMR 430.153)

1) ***Religious Exceptions:*** If a camper or staff member has religious objections to physical examinations or immunizations, the camper or staff member shall submit a written statement, signed by a parent or legal guardian for those under 18 years of age, to the effect that the individual is in good health and stating the reason for such objections.
2) ***Immunizations Contraindicated:*** Any immunization specified in 105 CMR 430.152 shall not be required if the health history required by 105 CMR 430.151 includes a certification by a physician that he or she has examined the individual and that, in the physician's opinion, the physical condition of the individual is such that his or her health would be endangered by such immunization.

IMMUNIZATION DATES – *LIST MONTH AND YEAR*

DTP_____ MMR _____

dT _____ MEASLES _____

POLIO _____ MUMPS _____

HIB _____ RUBELLA _____

FORM MUST BE SIGNED BY AND DATED BY PHYSICIAN OR DESIGNEE (NOT PARENT OR GUARDIAN!)

SIGNED _____ **DATE** _____

AUTHORIZATION TO ADMINISTER MEDICATION TO A CAMPER

I hereby authorize E. Paul Robsham Scout Reservation to administer, to my child,

_____ (Name of Child) the medication(s) listed below, in accordance

with 105 CMR 430.160.

Name(s) of Medications

_____

_____

_____

_____

_____

_____

105 CMR 430.160(A)
Medication prescribed for campers shall be kept in original containers bearing the pharmacy label, which shows the date of filling, the pharmacy name and address, the filling pharmacist's initials, the serial number of the prescription, the name of the patient, the name of the prescribing practitioner, the name of the prescribed medication, directions for use and cautionary statements, if any, contained in such prescription or required by law, and if tablets or capsules, the number in the container. All over the counter medications for campers shall be kept in the original containers containing the original label, which shall include the directions for use.
105 CMR 430.160(C)
Medication shall only be administered by the health supervisor* or by a licensed health care professional authorized to administer prescription medications. The health care consultant shall acknowledge in writing the list of medications administered at the camp. If the health supervisor is not a licensed health care professional authorized to administer prescription medications, the administration of medications shall be under the professional oversight of the health care consultant. Medication prescribed for campers brought from home shall only be administered if it is from the original container, and there is written permission from the parent/guardian.
105 CMR 430.160(D)
When no longer needed, medications shall be returned to a parent of guardian whenever]possible. If the medication cannot be returned, it shall be destroyed.
*Health Supervisor – A person who is at least 18 years of age, specially trained and certified in at least current American Red Cross First Aid (or its equivalent) and CPR, has been trained in the administration of medications and is under the professional oversight of a licensed health care professional authorized to administer prescription medications.

Parent/Guardian Signature: _____ Date: _____