



Personal Health and Medical Record

BSA - CLASS 2

Youth Member	<input type="checkbox"/>
Adult Under 40	<input type="checkbox"/>

Last Name _____
 First Name _____
 DOB ____/____/____
 Social Security # _____
 Unit# _____

This form is required once every 36 months for all participants under 40 years of age for the following activities: summer camps and other activities such as backpacking, tour camping or recreational sports lasting longer than 72 hours, where medical care is readily available. Not for high adventure use (use Class 3 form).

NOTE: If the participant has had a medical evaluation within the prior 36 months by a licensed health care practitioner, you may attach a copy in lieu of the medical evaluation on the reverse of this form. The evaluation must include the practitioner's signature and date. A recent examination within the past 6 months is required of any participant who is currently under medical care, 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 head injury.

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

IDENTIFICATION

Name _____ DOB ____/____/____ Age ____ Sex ____

Name of parent or guardian _____ Telephone ____/____/____

Home address _____ City _____ State _____ Zip _____

If parent or guardian 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 insurance carrier _____ Policy No. _____

I give my 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 ____/____/20____ Signature of parent/guardian or adult _____

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	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions/seizures	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
						Surgery	<input type="checkbox"/>	<input type="checkbox"/>

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 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, glasses, contact lenses, etc: _____

Immunizations: (Give date most recent)

Tetanus _____	Measles _____	Polio _____
Diphtheria _____	Mumps _____	Hepatitis B _____
Pertussis _____	Rubella _____	

CLASS 2 MEDICAL EVALUATION

(Read additional requirements outlined on front of form)

Name _____ DOB ____ / ____ / ____ 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 _____

URINALYSIS (when indicated): Albumin _____ Sugar _____

Check Box:	Norm	Abn		Norm	Abn		Norm	Abn
Growth development	<input type="checkbox"/>	<input type="checkbox"/>	Teeth	<input type="checkbox"/>	<input type="checkbox"/>	Genitalia	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>	Cardiopulmonary system	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>
HEENT	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Neurobehavioral	<input type="checkbox"/>	<input type="checkbox"/>

Explain any abnormal finding _____

Approved for all activities (hiking, camping, water activities, and vigorous sports) **Yes** **No** (list below)

LIMITATIONS:

Activity restrictions _____

Diet restrictions _____

Signature _____ M.D./D.O. Date ____ / ____ /20 ____

Name (print) _____ Telephone ____ / ____

Address _____

City, State, Zip _____

Physician’s Office Stamp

Record of findings, diagnoses, treatment, instructions or dispositions since evaluation

Date/Place	Action	By

Keep original form for your personal use. Make copies for unit or camp use. Be sure information and signatures are legible on copies