Annual Health and Medical Record

(Valid for 12 calendar months)

Policy on Use of the Annual Health and Medical Record

In order to provide better care for its members and to assist them in better understanding their own physical capabilities, the Boy Scouts of America recommends that everyone who participates in a Scouting event have an annual medical evaluation by a certified and licensed health-care provider—a physician (MD or DO), nurse practitioner, or physician assistant. Providing your medical information on this four-part form will help ensure you meet the minimum standards for participation in various activities. Note that unit leaders must always protect the privacy of unit participants by protecting their medical information.

Parts A and B are to be completed at least annually by participants in all Scouting events. This health history, parental/guardian informed consent and hold harmless/release agreement, and talent release statement is to be completed by the participant and parents/guardians.

Part C is the physical exam that is required for participants in any event that exceeds 72 consecutive hours, for all high-adventure base participants, or when the nature of the activity is strenuous and demanding. Service projects or work weekends may fit this description. Part C is to be completed and signed by a certified and licensed heath-care provider—physician (MD or DO), nurse practitioner, or physician assistant. It is important to note that the height/weight limits must be strictly adhered to when the event will take the unit more than 30 minutes away from an emergency vehicle–accessible roadway, or when the program requires it, such as backpacking trips, high-adventure activities, and conservation projects in remote areas. See the FAQs for when this does not apply.

Please note this health form contains an additional section.
The Colorado Department of Health Requires the attached form for ALL Scouts attending a camp located in the State of Colorado.
All sections of the Colorado form must be completed.

Annual BSA Health and Medical Record
Part A
GENERAL INFORMATION

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

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.)

This section requires additional information on P-5

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.

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Full name: _____ DOB: _____ Allergies: _____ Emergency contact No.: _____

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:

See P-5

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.

Part B **Full name:** _____ **DOB:** _____

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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	Range of Mobility	Normal	Abnormal	Explain Any Abnormalities
Eyes				Knees (both)			
Ears				Ankles (both)			
Nose				Spine			
Throat							
Lungs							
Neurological				**Other**	**Yes**	**No**	
Heart				Contacts			
Abdomen				Dentures			
Genitalia				Braces			
Skin				Inguinal hernia			**Explain**
Emotional adjustment				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): _____

See P-5

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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COLORADO LAW REQUIRES THAT THIS FORM BE COMPLETED FOR EACH SCOUT ATTENDING A COLORADO SCOUT CAMP

Name_____ **Date of Birth**_____

Parent/Guardian_____ **Dates of the Camp Session**_____

COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT CERTIFICATE OF IMMUNIZATION

Vaccine		(Enter the month, day and year each immunization was given.)					
Hep B	Hepatitis B						
DTaP	Diphtheria, Tetanus, Pertussis (pediatric)						
DT	Diphtheria, Tetanus (pediatric)						
Tdap	Tetanus, Diphtheria, Pertussis						
Td	Tetanus, Diphtheria						
Hib	*Haemophilus influenzae* type b						
IPV/OPV	Polio						
PCV	Pneumococcal Conjugate						
MMR	Measles, Mumps, Rubella						
Varicella	Chickenpox			Healthcare Provider Documentation Date_____		Lab Verification Date_____	

STATEMENT OF EXEMPTION TO IMMUNIZATION LAW

IN THE EVENT OF AN OUTBREAK, EXEMPTED PERSONS MAY BE SUBJECT TO EXCLUSION FROM CAMP AND TO QUARANTINE.

MEDICAL EXEMPTION: The physical condition of the above named person is such that immunization would endanger life or health or is medically contraindicated due to other medical conditions.

Signed _____ Date _____
Physician (Medico)

Medical exemption *to the following vaccine(s):*
La exención por razones médicas *aplica a la(s) siguiente(s) vacuna(s):*

☐ HepB ☐ DTaP ☐ Tdap ☐ Hib ☐ IPV ☐ PCV ☐ MMR ☐ VAR

RELIGIOUS EXEMPTION: Parent or guardian of the above named person or the person himself/herself is an adherent to a religious belief opposed to immunizations.

Signed _____ Date _____
Parent, guardian, emancipated Scout/counseling minor

Religious exemption *to the following vaccine(s):*
Exención por motives religiosos *de la(s) siguiente(s) vacuna(s):*

☐ HepB ☐ DTaP ☐ Tdap ☐ Hib ☐ IPV ☐ PCV ☐ MMR ☐ VAR

PERSONAL EXEMPTION: Parent or guardian of the above named person or the person himself/herself is an adherent to a personal belief opposed to immunizations.

Signed _____ Date _____
Parent, guardian, emancipated Scout/counseling minor

Personal exemption *to the following vaccine(s):*
Exención por creencias personales *de la(s) siguiente(s) vacuna(s):*

☐ HepB ☐ DTaP ☐ Tdap ☐ Hib ☐ IPV ☐ PCV ☐ MMR ☐ VAR

PARENT/GUARDIAN AUTHORIZATIONS

Parent/Guardian Name_____
Parent/Guardian Address_____
Parent/Guardian Telephone Day_____
Eve_____ Cell_____
Place of Employment_____
Address_____
Phone #_____

Parent/Guardian Name_____
Parent/Guardian Address_____
Parent/Guardian Telephone Day_____
Eve_____ Cell_____
Place of Employment_____
Address_____
Phone #_____

Individual authorized to take the Scout from camp if different from the parent or guardian:
Name_____ Address_____ City_____ ST____ Zip_____
Phone # Day_____ Eve_____ Cell_____

I hereby authorize the above named person to participate in all special trips or excursions in which the Scout may be walking or riding away from the campsite.
Parent/Guardian/Custodial Adult_____ Date_____

The above named person is restricted from the activities listed below:
_____ _____
_____ _____
_____ _____
_____ _____

Parent/Guardian/Custodial Adult_____ Date_____