BSA Health Care Form Information Sheet

The purpose of this email is to assist the Scout Master in ensuring that the BSA Health Care Form is prepared prior to arriving at camp. By making sure that this is accomplished we can make the check-in process as streamlined as possible.

First let's start with Form A.

Make sure that the Full Name and DOB (Date of Birth) are filled in, also please make sure that it is legible. This will help us quickly access your child's medical record in the event of an Emergency.

Beneath the exclamation point is a box and a line to define what activities the scout will be allowed to do while at camp. If there are any restrictions (ex: Doesn't know how to swim, cannot participate in high impact activities due to previous concussions, etc.) please describe them in that designated spot, if there are no restrictions, please mark the box labeled "None".

Please ensure that both the parents/legal guardians have signed the form and that the scout has signed as well if he is old enough.

Any adult that will be taking the scout home or leaving with a Scout must have authorization and this form is the place to give that authorization, please fill out the section below the signature block with the names and phone numbers of those adults who can assume responsibility. Should you want to prevent a particular person from transporting your child, you are expected to fill out the names of those who are NOT authorized.

Form B page 1

Once again please ensure that the name and DOB section is legibly filled out.

Please fill out the general information section in its entirety. During an emergency it is difficult enough contacting family and finding scout masters and tracking down medical history information. By ensuring that this section is completely filled out we can limit the time spent preparing for transport and quickly get the scout to medical attention.

Please staple a copy of the medical insurance card to the back of the packet.

IMPORTANT Please list an emergency contact. This will typically be someone that we can contact should we not be able to reach the immediate family for whatever reason.

Please select yes/no for the different medical history areas; any "YES" blocks must be explained.

Form B page 2

Please select yes/no for the different allergies.

Form B page 2 cont.

Please check the block stating that there are no medications if the Scout does not take any regular medications. Should the Scout be taking medications ensure that the medications and the dosages on the form match the dosages on the original pill bottles that are brought to camp. The medic will not be able to accept any undeclared medications or medications that are expired or are asked to take at times not listed on the prescription.

Important Beneath the medications list area is a statement with a YES/NO block. Checking "Yes" means that the Health Officer may administer non-prescription medication to your child in the event of an emergency as well as generic over the counter medications such as Tums for a stomach ache or Benadryl for a bad allergic reaction. If "YES" is not checked and if the parent/guardian does not sign then the Scout will not be able to receive potentially live saving medication while in route to the hospital which is 1 hour away. In the space after the yes/no block is an area where the parent/guardian may list any medications that he/she does not want the scout to receive.

Important BSA policy states that no person may be at camp if they have not received a Tetanus shot within the last 10 years. Please fill out the Immunization area completely. Scouts will be sent home if this area is not completely filled out. Should they not have received their Tetanus immunization for religious reasons please state this; should the Scout become injured while at camp he/she will be promptly transported to medical care.

If there is any other pertinent medical history please use the blank space to the right of the immunization form to describe that information.

Form C

Important Anyone staying in camp for longer than 72 hours (3 days) must have Form C filled out completely with an MD/DO/PA/NP or any other primary health care provider's signature.

Important areas on this form include the authorizations area near the top that limits the activities that the scout may participate in. This is the same as the authorization area on Form A but this is approved by a medical doctor.

If you have any questions regarding the form please contact the scout office immediately, the first afternoon during orientation is not the time to present questions as this might be too late to find that last signature.

Part A: Informed Consent, Release Agreement, and Authorization

Full name: _____

DOB: _____

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

Informed Consent, Release Agreement, and Authorization
I understand that participation in Scouting activities involves the risk of personal injury, including death, due to the physical, mental, and emotional challenges in the activities offered. Information about those activities may be obtained from the venue, activity coordinators, or your local council. I also understand that participation in these activities is entirely voluntary and requires participants to follow instructions and abide by all applicable rules and the standards of conduct.

In case of an emergency involving me or my child, I understand that efforts will be made to contact the individual listed as the emergency contact person by the medical provider and/or adult leader. 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.

(If applicable) I have carefully considered the risk involved and hereby give my informed consent for my child to participate in all activities offered in the program. I further authorize the sharing of the information on this form with any BSA volunteers or professionals who need to know of medical conditions that may require special consideration in conducting Scouting activities.

With appreciation of the dangers and risks associated with programs and activities, on my own behalf and/or on behalf of my child, I hereby fully and completely release and waive any and all claims for personal injury, death, or loss that may arise against the Boy Scouts of America, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with any program or activity.

I also hereby assign and grant to the local council and the Boy Scouts of America, as well as their authorized representatives, 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 further 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 BSA, and I specifically waive any right to any compensation I may have for any of the foregoing.

! **NOTE: Due to the nature of programs and activities, the Boy Scouts of America and local councils cannot continually monitor compliance of program participants or any limitations imposed upon them by parents or medical providers. However, so that leaders can be as familiar as possible with any limitations, list any restrictions imposed on a child participant in connection with programs or activities below.** !

List participant restrictions, if any: ☐ **None**

_____

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, Florida Sea Base, or the Summit Bechtel Reserve, I have also read and understand the supplemental risk advisories, 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. If the participant is under the age of 18, a parent or guardian's signature is required.

Participant's signature: _____ Date: _____

Parent/guardian signature for youth: _____ Date: _____

(If participant is under the age of 18)

Second parent/guardian signature for youth: _____ Date: _____

(If required; for example, California)

Complete this section for youth participants only:

Adults Authorized to Take to and From Events:
You must designate at least one adult. Please include a telephone number.

Name: _____ Name: _____

Telephone: _____ Telephone: _____

Adults NOT Authorized to Take Youth To and From Events:

Name: _____ Name: _____

Telephone: _____ Telephone: _____

Part B: General Information/Health History

Full name: _____

DOB: _____

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

Age: _____ Gender: _____ Height (inches): _____ Weight (lbs.): _____

Address: _____

City: _____ State: _____ ZIP code: _____ Telephone: _____

Unit leader: _____ Mobile phone: _____

Council Name/No.: _____ Unit No.: _____

Health/Accident Insurance Company: _____ Policy No.: _____

! **Please attach a photocopy of both sides of the insurance card. If you do not have medical insurance, enter "none" above.** !

In case of emergency, notify the person below:

Name: _____ Relationship: _____

Address: _____ Home phone: _____ Other phone: _____

Alternate contact name: _____ Alternate's phone: _____

Health History

Do you currently have or have you ever been treated for any of the following?

Yes	No	Condition	Explain
☐	☐	Diabetes	**Last HbA1c percentage and date**:
☐	☐	Hypertension (high blood pressure)	
☐	☐	Adult or congenital heart disease/heart attack/chest pain (angina)/heart murmur/coronary artery disease. Any heart surgery or procedure. Explain all "yes" answers.	
☐	☐	Family history of heart disease or any sudden heart-related death of a family member before age 50.	
☐	☐	Stroke/TIA	
☐	☐	Asthma	**Last attack date**:
☐	☐	Lung/respiratory disease	
☐	☐	COPD	
☐	☐	Ear/eyes/nose/sinus problems	
☐	☐	Muscular/skeletal condition/muscle or bone issues	
☐	☐	Head injury/concussion	
☐	☐	Altitude sickness	
☐	☐	Psychiatric/psychological or emotional difficulties	
☐	☐	Behavioral/neurological disorders	
☐	☐	Blood disorders/sickle cell disease	
☐	☐	Fainting spells and dizziness	
☐	☐	Kidney disease	
☐	☐	Seizures	**Last seizure date**:
☐	☐	Abdominal/stomach/digestive problems	
☐	☐	Thyroid disease	
☐	☐	Excessive fatigue	
☐	☐	Obstructive sleep apnea/sleep disorders	**CPAP: Yes** ☐ **No** ☐
☐	☐	List all surgeries and hospitalizations	**Last surgery date**:
☐	☐	List any other medical conditions not covered above	

Part B: General Information/Health History

Full name: _____

DOB: _____

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

Allergies/Medications

Are you allergic to or do you have any adverse reaction to any of the following?

Yes	No	Allergies or Reactions	Explain	Yes	No	Allergies or Reactions	Explain
☐	☐	Medication		☐	☐	Plants	
☐	☐	Food		☐	☐	Insect bites/stings	

List all medications currently used, including any over-the-counter medications.

☐ **CHECK HERE IF NO MEDICATIONS ARE ROUTINELY TAKEN.**

☐ **IF ADDITIONAL SPACE IS NEEDED, PLEASE INDICATE ON A SEPARATE SHEET AND ATTACH.**

Medication	Dose	Frequency	Reason

☐ **YES** ☐ **NO** **Non-prescription medication administration is authorized with these exceptions:** _____

Administration of the above medications is approved for youth by:

_____ / _____

Parent/guardian signature **MD/DO, NP, or PA signature (if your state requires signature)**

! **Bring enough medications in sufficient quantities and in the original containers. Make sure that they are NOT expired, including inhalers and EpiPens. You SHOULD NOT STOP taking any maintenance medication unless instructed to do so by your doctor.** **!**

Immunization

The following immunizations are recommended by the BSA. Tetanus immunization is required and must have been received within the last 10 years. If you had the disease, check the disease column and list the date. If immunized, check yes and provide the year received.

Yes	No	Had Disease	Immunization	Date(s)
☐	☐	☐	Tetanus	
☐	☐	☐	Pertussis	
☐	☐	☐	Diphtheria	
☐	☐	☐	Measles/mumps/rubella	
☐	☐	☐	Polio	
☐	☐	☐	Chicken Pox	
☐	☐	☐	Hepatitis A	
☐	☐	☐	Hepatitis B	
☐	☐	☐	Meningitis	
☐	☐	☐	Influenza	
☐	☐	☐	Other (i.e., HIB)	
☐	☐	☐	Exemption to immunizations (**form required**)	

Please list any additional information about your medical history:

DO NOT WRITE IN THIS BOX
Review for camp or special activity.

Reviewed by: _____

Date: _____

Further approval required: ☐ Yes ☐ No

Reason: _____

Approved by: _____

Date: _____

Part C: Pre-Participation Physical

This part must be completed by certified and licensed physicians (MD, DO), nurse practitioners, or physician assistants.

Full name: _____

DOB: _____

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

You are being asked to certify that this individual has no contraindication for participation inside a Scouting experience. For individuals who will be attending a high-adventure program, including one of the national high-adventure bases, please refer to the supplemental information on the following pages or the form provided by your patient.

Examiner: Please fill in the following information:

	Yes	No	Explain
Medical restrictions to participate	☐	☐	

Yes	No	Allergies or Reactions	Explain	Yes	No	Allergies or Reactions	Explain
☐	☐	Medication		☐	☐	Plants	
☐	☐	Food		☐	☐	Insect bites/stings	

Height (inches):_____ **Weight (lbs.):**_____ **BMI:**_____ **Blood Pressure:**_____/_____ **Pulse:**_____

	Normal	Abnormal	Explain Abnormalities
Eyes	☐	☐	
Ears/nose/throat	☐	☐	
Lungs	☐	☐	
Heart	☐	☐	
Abdomen	☐	☐	
Genitalia/hernia	☐	☐	
Musculoskeletal	☐	☐	
Neurological	☐	☐	
Other	☐	☐	

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):

True	False	Explain
☐	☐	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 his or her 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.
☐	☐	**For high-adventure participants, I have reviewed with them the important supplemental risk advisory provided.**

Examiner's Signature: _____ **Date:** _____

Provider printed name: _____

Address: _____

City: _____ State: _____ ZIP code: _____

Office phone: _____

Height/Weight Restrictions
If you exceed the maximum weight for height as explained in the following chart and your planned high-adventure activity will take you more than 30 minutes away from an emergency vehicle/accessible roadway, you may not be allowed to participate.

Maximum weight for height:

Height (inches)	Max. Weight	Height (inches)	Max. Weight	Height (inches)	Max. Weight	Height (inches)	Max. Weight
60	166	65	195	70	226	75	260
61	172	66	201	71	233	76	267
62	178	67	207	72	239	77	274
63	183	68	214	73	246	78	281
64	189	69	220	74	252	79 and over	295