PERSONAL HEALTH AND MEDICAL RECORD

CLASS 1 AND CLASS 2

SAM HOUSTON AREA COUNCIL, B.S.A.

2007 - 2009

Class 1 (update annually for all participants). Activity: Day Camp, overnight hike, or other programs not exceeding 72 hours, with level of activity similar to that of home or school. Medical care is readily available. Current personal health and medical summary (history) is attested by parents to be accurate. This form is filled out by all participants and is on file for easy reference.

CLASS 1 PERSONAL HEALTH AND MEDICAL HISTORY
(Annually by all participants)

To be filled out by parent, guardian, or adult participant. Please PRINT IN INK.

IDENTIFICATION

Name_____Date of Birth_____Age_____Sex_____

Name of parent or guardian_____Telephone_____

Home address_____City_____State_____Zip_____

Business address_____City_____State_____Zip_____

If person named above is not available in the event of an emergency, contact:

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

Name of personal physician_____Phone_____

Personal health/accident insurance carrier_____Policy No._____

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)	☐	☐	Convulsions/Seizures	☐	☐	Hemophillia	☐	☐
Asthma	☐	☐	Diabetes	☐	☐	High Blood Pressure	☐	☐
Cancer/leukemia	☐	☐	Heart Trouble	☐	☐	Kidney Disease	☐	☐

Explain:_____

List any medications to be taken at camp:_____

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, braces, glasses, contact lenses, etc:_____

Immunizations: (Give date of last inoculation.)

Tetanus toxoid_____ Measles_____ Polio_____

Diphtheria _____ Mumps _____ Hepatitis B_____

Pertussis _____ Rubella _____ _____

I give permission for full participation in BSA program, subject to limitations noted herein.

In case of emergency, I understand every effort will be made to contact me (if an adult, my spouse or next of kin). In the event I cannot be reached, I hereby give my permission to the physician 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 an adult).

Date_____Signature of parent/guardian or adult_____

Some hospitals require the parent/guardian signature to be notarized.

NAME_____ TROOP_____ CAMPSITE_____

Class 2 (required once every 36 months for all participants under 40 years of age). Activity: Resident camp or any other activity such as backpacking, tour camping, or recreational sports involving events lasting longer than 72 consecutive hours, with level of activity similar to that at home or school. Medical care is readily available.

> The state of ARKANSAS, COLORADO, DELAWARE, MASSACHUSETTS, and NEW HAMPSHIRE require an annual physical examination, therefore all Scouts attending a Scout Camp in these states **must** have an annual physical examination.

If your child has had a medical evaluation **(physical examination)** within the last 36 months, a copy of the results of this examination must be attached to the health history for all participants in a camping experience lasting longer than 72 consecutive hours. If a copy is not available, a physical examination (using the Class 2 section of this form) must be scheduled by a licensed practitioner*. This medical examination (physical examination) also is required if your child is currently under medical care, takes a prescribed medication, 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 suffered a concussion from a head injury.

In TEXAS, Doctors of Chiropractic services my administer physical examination.

THIS FORM IS NOT TO BE USED BY ADULTS OVER 40, BY HIGH-ADVENTURE PARTICIPANTS (USE FORM NO. 34412), OR FOR NATIONAL SCOUT JAMBOREE (USE FORM NSJ-34412)

CLASS 2 MEDICAL EVALUATION

Name_____**Age**_____

NOTE TO LICENSED MEDICAL PRACTITIONERS*: The person being evaluated will be attending 1 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 medical practitioner)

Height_____**Weight**_____**BP**_____/_____**Pulse**_____

Lab: Urinalysis (dipstick)_____**Albumin**_____**Sugar**_____

VISION Normal_____**Glasses**_____**Contacts**_____

HEARING: Normal_____**Abnormal**_____**Explain**_____

CHECK BOX:	**N**	**ABN**		**N**	**ABN**		**N**	**ABN**
Growth development	☐	☐	**Teeth**	☐	☐	**Genitalia**	☐	☐
Skin	☐	☐	**Cardiopulmanary system**	☐	☐	**Musculoskeletal**	☐	☐
HEENT	☐	☐	**Hernia**	☐	☐	**Neurobehavioral**	☐	☐

Explain_____

LIMITATIONS

Activity restrictions_____

Diet restrictions_____

Signature_____**M.D./D.O./D.C/P.A/R.N.P.*** Date_____

Address_____Phone_____

City, State, ZIP_____

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.

INTERVAL RECORD	SCREENING EXAMINATION	
DATE, TIME, PLACE, ETC.	**(Findings, diagnoses, treatment, instruments, disposition, etc.)**	**BY**

A PHOTOCOPY OF THIS FORM IS PERMITTED

NAME_____ **TROOP**_____ **CAMPSITE**_____