Colorado Boy Scout Camps Health & Medical Record

This form is valid for 24 months for persons under 40 years of age and 12 months for persons 40 years of age and older.
Personal Health and Medical Record—Class 1 and 3
Instructions: By completing sections 1, 2, and 3, this form qualifies as a Class 1 medical history. By completing all sections (page 1 and 2); this form qualifies as a Class 2 or 3 medical record.
Who needs a Class 1? Anyone attending Cub Scout Day Camps and any overnight activities less than 72 hours.
Who needs a Class 3? Anyone attending a high Adventure Base or Boy Scout Camp (longer than 72 hours).

NOTE: ALL MEDICATIONS MUST BE IN ORIGINAL CONTAINER WITH PHARMACY LABEL!

LAST NAME _____ FIRST INITIAL _____ ALLERGIES _____

UNIT # _____ SESSION # _____

1. Personal and Emergency Contact Information

Name: _____ Date of Birth: _____ Age: _____ Sex: _____
Address: _____ City, State, Zip _____ Phone: _____

Name of Mother/Guardian/Spouse: _____
Phone: _____ E-mail: _____
Address: _____
City, State, Zip: _____
Place of Employment: _____
Phone: _____

Name of Father/Guardian/Spouse: _____
Phone: _____ E-mail: _____
Address: _____
City, State, Zip: _____
Place of Employment: _____
Phone: _____

If above persons are not available in the event of an emergency, please contact:
Name: _____ Phone: _____ Name: _____ Phone: _____

Adults authorized to take youth to and from the event:
(You must designate an adult. Please include phone number)

_____
_____
_____

Persons NOT authorized to take youth to and from the event:

_____
_____
_____

2. Health History Information

Name of Primary Physician: _____
Phone; _____
City, State: _____
Medical Insurance Provider: _____
Carrier's Name: _____
Policy or Group Number: _____
Medicaid ID #: _____
Medications taken in the last 30 days: _____
_____
_____
Medications to be continued at event and dose: _____
_____
_____
_____
Special Instruction related to any medications: _____
_____
_____
Any activities participant cannot participate in: _____
_____
_____

Food Allergies: _____
Plant Allergies: _____
Insect/Animal Allergies: _____
Other Allergies: _____

	YES	NO	Explain
Serious Illness			
Serious Injury			
Deformity			
Surgery			
Ears, Eyes			
Nose, Sinus			
Teeth/Tonsils			
Chest, Lungs			
Heart Murmur			
Rheumatic Fever			
Appendicitis			
Kidney or Urine			
Menstrual problems			
Hernia			
Back, Limbs, Joints			
Sleepwalking			
Nervous Conditions			
Other (explain)			
Diet Restrictions			

3. Parent/Minor Signature

This health history is correct so far as I know, and is up to date as of the last 90 days. The person herein described has permission to engage in all prescribed camp activities except as noted. Emergency Authorization: I hereby give permission to the medical personnel selected by the camp officials to order x-rays, routine tests and treatment for me or my child, as in the event I cannot be reached in an emergency. I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for me or my child as named above. I hereby give permission to transport me or my child for medical assistance. I hereby give permission to Boy Scouts of America to use photos, likenesses, and images of me for marketing and publicity purposes. This form may be photocopied for use at camp. I understand that I am responsible for payment of all medical treatments received from non-camp sources. I also give permission for the camp medical staff to administer over-the-counter medications to my child, that the physician has approved on page 2 of this form.
I also give permission for my child to go on trips away from camp premises, and to participate in all camp activities.

***Signature of parent or guardian (or participant if over 18): _____ Date: _____

***Signature of Minor: _____ Date: _____

4. Immunization History

Required Immunizations must be determined locally. Please record the date (month and year) of basic immunizations and most recent booster doses. If disease has occurred, indicate with a "D". **The State of Colorado requires dates!**

	Dates of Immunizations/Boosters				
DTP/DTaP - Diptheria - Tetanus - Pertussis					
Td/DT - Tetanus - Diptheria					
OPV/IPV - Polio					
Hib - Haemophilus influenzae type b					
MMR - Measles - Mumps - Rubella					
HB - Hepatitis B					
Varicella - Chicken Pox					
Other					
Other					
Other					

To the best of my knowledge, the person named above has received the above immunizations.
Signed: _____ Title: _____ (Physician, Nurse, or School Health Authority)

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. Signature: _____ Date: _____
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. Signature: _____ Date: _____
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. Signature: _____ Date: _____

5. Medical Examination by Licensed Physician

Instructions to Licensed Health-Care Practitioner:

1. This applicant will be participating in a strenuous activity that could 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.
2. Review complete medical history (part 2 on reverse side) furnished by applicant before beginning examination.
3. Review Immunizations history (part 4 above) and assure that immunizations are complete and up-to-date.

Date of Exam: _____
Height: _____ Weight: _____
Blood Pressure: _____ Pulse: _____
Vision: ____Normal Hearing: ____Normal
____Glasses ____Abnormal
____Contacts

	Normal	Abnormal		Normal	Abnormal
Growth Development			Neuro-psychiatric		
Skeleto-muscular			Genitourinary		
Abdomen, hernia, rings			Cardiovascular		
Respiratory			Teeth, Tonsils		
Skin, glands, hair			Eyes, ears, nose		
Head, neck, thyroid			Other		

6. Physician's Evaluation and Advice

Approved for participation in:
_____Hiking _____Water Activities
_____Competitive Sports _____All Activities
Specify Exceptions: _____
_____
Explain any restrictions or limitations: _____
_____

7. Authorization for Administration of Prescription Medication

Name of Medicine: _____
Date Prescribed: _____
Dosage and Directions for Use (and frequency):_____
_____
Name of Medicine: _____
Date Prescribed: _____
Dosage and Directions for Use (and frequency):_____
_____
Name of Medicine: _____
Date Prescribed: _____
Dosage and Directions for Use (and frequency):_____
_____
_____
Name of Medicine: _____
Date Prescribed: _____
Dosage and Directions for Use (and frequency):_____
_____

❑ See attached list for additional medications

ALL MEDICATIONS MUST BE IN ORIGINAL CONTAINER WITH PHARMACY LABEL!

8. Authorization for administration of Over-the-Counter Medications

BSA Health Officials are authorized to administer the following over-the-counter medications at the recommended doses:

___Tylenol ___Ibuprofen
___Benadryl ___Cough Drops
Other (please specify):_____
_____
Allergy to (please ***DO NOT*** give these medications):
_____
_____

Physician's Signature (Certifying sections 5, 6, 7, & 8)

Licensed Physician Signature: _____ Date: _____
Physician Name (printed): _____ City, State: _____

In addition to examinations conducted by medical doctors and doctors of osteopathy, examinations by registered nurse practitioners will be recognized.