

PERSONAL HEALTH AND MEDICAL RECORD FORM—Class 3

I. IDENTIFICATION Age _____ Sex _____ Date of Birth* _____

Name _____
 Last name First name Initial Mo. Day Year

Address _____

City & State _____ Zip _____

Health/Accident insurance _____ Policy no. _____

IN AN EMERGENCY NOTIFY:

Name _____ Relationship _____

Address _____ Home phone _____

City & State _____ Business phone _____

Personal Physician _____ Phone _____

BOY SCOUTS OF AMERICA

All Class 3 activities require a health examination within the past 12 months by a licensed health-care practitioner.* This includes youth and adult members participating in high-adventure activities, athletic competition, and world jamborees. Annually, this form is to be used by adults over 40 for all activities requiring a physical examination and applies to *all* Wood Badge participants/staff regardless of age.

PLEASE TYPE OR PRINT.

NOTE: Keep original form for your personal record. Make reproductions for agency use. Be sure information and signatures are legible on reproduced copies. This upper section may be reproduced and carried with you for emergency identification and care.

NAME _____ UNIT _____

II. EMERGENCY MEDICAL INFORMATION

Has or is subject to (check and give details):


Allergy to a medicine, food†, plant, animal, or insect toxin

Any condition that may require special care, medication, or diet

ADHD (Attention Deficit Hyperactive Disorder)

Asthma Convulsions Heart trouble Contact lenses

Diabetes† Fainting spells Bleeding disorders Dentures

 EXPLAIN _____

III. PARENTAL STATEMENT

Has it ever been necessary to restrict applicant's activities for medical reasons? No Yes Does applicant take medicine regularly or have special care? No Yes If yes, explain.

To the best of my knowledge, the information in sections I, II, III, IV, and VI is accurate and complete. I request a licensed health-care practitioner to examine applicant, to give needed immunization, and to furnish requested information to other agencies as needed. I give my permission for full participation in BSA programs, subject to limitations noted herein. In the event of illness or accident in the course of such activity, I request that measures be instituted without delay as judgment of medical personnel dictates.

Parent or guardian _____
 (Must sign if applicant is 18 or younger)

Applicant's signature _____

Date signed _____

IV. IMMUNIZATIONS

If disease, put "D" and year.

Last year given _____

Tetanus _____

Diphtheria _____

Pertussis _____

Measles _____

Mumps _____

Rubella _____

Polio _____

Chicken Pox _____

Religious preference _____

V. LICENSED HEALTH-CARE PRACTITIONER'S EVALUATION AND ADVICE

Approved for participation in:

Hiking and camping Water activities

Competitive sports All activities

Specify exceptions _____

Recommendations (explain any restrictions OR limitations): _____

_____ Date _____

Signed _____
 *Licensed health-care practitioner

*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.

VI. MEDICAL HISTORY

Parent (or applicant if 18 or older): Fill in sections I, II, III, IV, and VI before seeing a licensed health-care practitioner. Check immunizations to be given at this time. Be sure to include any emergency information and restrictions or special care that should be observed. Especially be sure to record any injuries, illnesses, surgery, or significant changes in condition of health of applicant since last complete examination.

- Date of most recent complete physical examination (month and year) _____ 19____
- Are you aware of any current health problems? No Yes
- Now under medical care or taking medicines? No Yes
- Has there been any surgery, injury, illness, allergy, or change in health status since last complete physical examination? No Yes

Give dates and full details below for any "yes" answers.

IS THERE DISEASE OF (OR PAST OR PRESENT HISTORY OF):

	No	Yes	Year	Details/Medicines
Serious illness	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Serious injury	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Deformity	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Skin, glands	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Ears, eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Nose, sinus	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Teeth, tonsils	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Dentures	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Bridge	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Chest, lungs	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Heart	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Murmur	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Stomach, bowels	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Appendicitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Kidneys or urine	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Albumin	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Sugar	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Infection	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Bed-wetting	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Menstrual problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hernia (rupture)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Back, limbs, joints	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Sleepwalking	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Nervous condition	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Other (explain)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Please list ALL medications taken in the 30 days prior to arrival at the Scouting activity where this form is to be used:

VII. HEALTH EXAMINATION

Licensed Health-Care Practitioner: _____

The applicant will be participating in a strenuous activity that will include one or more of the following conditions: athletic competition, adventure challenge or wilderness expedition (afloat 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.

- Please insist applicant furnish complete medical history (VI) before exam.
- Review immunizations; for youth (18 or younger) tetanus and diphtheria toxoids, measles, mumps, and rubella vaccines, and trivalent oral polio vaccine are required; youths and adults must have had tetanus booster within 10 years. A measles booster is recommended at age 12.
- After completing section VII, summarize any restrictions and/or recommendations in sections II and V, above, and sign.

Date _____ VISION: _____ HEARING: _____

Ht. _____ Wt. _____ Normal _____ Normal _____

B.P. _____ / _____ Pulse _____ Glasses _____ Abnormal _____

Contacts _____

Check box if normal; circle if abnormal and give details below:

Growth, development Teeth, tonsils Genitourinary

Skin, glands, hair Respiratory Skeletomuscular

Head, neck, thyroid Cardiovascular Neuropsychiatric

Eyes, ears, nose Abdomen, hernia, rings Other (specify) _____

COMMENTS

FOR THOSE ATTENDING PHILMONT OR NATIONAL HIGH-ADVENTURE BASES:

* The minimum age for all participants is 13 by January 1 of the year of participation, or have completed the seventh grade. No exceptions.

† Trail food is by necessity a high-carbohydrate, high-calorie diet. It is high in wheat, milk products, sugar, corn syrup, and artificial coloring/flavoring. Dinner meals contain meat. If these food products cause a problem in your diet, you need to bring appropriate substitutions with you and so advise base personnel.

Note: Licensed health-care practitioners representing high-adventure bases reserve the right to deny access to the trails or other program activity on the basis of a medical evaluation performed at the base after arrival.

REVIEW FOR CAMP OR SPECIAL ACTIVITY

DATE	AGENCY AND ACTIVITY	BY	"OK"	PHYSICIAN RECHECK NEEDED	RESULTS OF RECHECK	INITIAL

INTERVAL RECORD

(CAMP, CAMPOREE, TOURNAMENT, TRAVEL, ETC.)

DATE, TIME, PLACE, ETC.	FINDINGS, DIAGNOSES, TREATMENT, INSTRUCTIONS, DISPOSITION, ETC.	BY:

Historical Only. DO NOT USE