

**PERSONAL HEALTH AND MEDICAL RECORD FORM—ADULT**

**I. IDENTIFICATION** Age \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth\* \_\_\_\_\_  
 Name \_\_\_\_\_  
 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.

**II. EMERGENCY MEDICAL INFORMATION:** Has or is subject to -  
 P 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** \_\_\_\_\_

**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 \_\_\_\_\_

**III. PARENTAL STATEMENT**

Has it ever been necessary to restrict applicant's activities for medical reasons?  No  Yes Does applicant take regular medicine 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 judgement of medical personnel dictates.

Parent or Guardian \_\_\_\_\_  
 (Must sign if applicant is under 18)

Applicant's Signature \_\_\_\_\_  
 Date signed \_\_\_\_\_

**IV. IMMUNIZATIONS**

	Last Year Given
TETANUS	_____
DIPHTHERIA	_____
POLIO	_____

Has had Vaccination Disease

MEASLES	<input type="checkbox"/>	<input type="checkbox"/>
MUMPS	<input type="checkbox"/>	<input type="checkbox"/>
RUBELLA	<input type="checkbox"/>	<input type="checkbox"/>
PERTUSSIS	<input type="checkbox"/>	<input type="checkbox"/>
CHICKEN POX	<input type="checkbox"/>	<input type="checkbox"/>

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) \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_  
 \*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**

**Applicant:** Fill in sections I, II, III, IV, VI, and VIII 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 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
Contagious disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	
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"/>	_____	
Emotional or Behavioral	<input type="checkbox"/>	<input type="checkbox"/>	_____	

**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 (under 18) 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.

VISION: \_\_\_\_\_ HEARING: \_\_\_\_\_  
 DATE \_\_\_\_\_ Normal \_\_\_\_\_  
 Ht. \_\_\_\_\_ Wt. \_\_\_\_\_ Glasses \_\_\_\_\_  
 B.P. \_\_\_\_\_ / \_\_\_\_\_ Pulse \_\_\_\_\_ Contacts \_\_\_\_\_

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

<input type="checkbox"/> Growth, development	<input type="checkbox"/> Teeth, tonsils	<input type="checkbox"/> Genitourinary
<input type="checkbox"/> Skin, glands, hair	<input type="checkbox"/> Respiratory	<input type="checkbox"/> Skeletomuscular
<input type="checkbox"/> Head, neck, thyroid	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Neuropsychiatric
<input type="checkbox"/> Eyes, ears, nose	<input type="checkbox"/> Abdomen, hernia, rings	<input type="checkbox"/> Other (specify)

COMMENTS \_\_\_\_\_

LABORATORY: Urinalysis (Dip stick) Albumin \_\_\_\_\_ Sugar \_\_\_\_\_

**VIII. LIST PRESCRIPTION AND NON-PRESCRIPTION MEDICINES IN THE SPACE BELOW:** (All medications must be in original containers.)

**See other side for State of Michigan Requirements.**

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:

**Instructions:**

This form is required once every 12 months for all adults over 40 years of age, High Adventure, and all Wood Badge participants/staff regardless of age. This form is required once every 36 months for adults under 40 years of age.

**The following is required by the Michigan Department of Social Services pursuant to PA 116 of 1973 and administrative rule 109.(4).**

Registration position in Council: \_\_\_\_\_ Position in camp: \_\_\_\_\_

Number of years/seasons in summer camp as an adult leader: \_\_\_\_\_ years.

Number of years in leadership of short-term weekend camping: \_\_\_\_\_ years.

Please indicate training received ... (I = date issued) (E = date expires):

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Lifesaving Merit Badge - I_____  | <input type="checkbox"/> BSA Adult Basic Ldr Trng - I_____  | <input type="checkbox"/> BSA National Camp School - E_____ |
| <input type="checkbox"/> ARC Basic Water Safety - I_____  | <input type="checkbox"/> ARC Multi-Media First Aid - E_____ | <input type="checkbox"/> Safe Swim Defense Trng - I_____   |
| <input type="checkbox"/> Water Safety Instructor - E_____ | <input type="checkbox"/> BSA Lifeguard Certified - I_____   | <input type="checkbox"/> Wood Badge Training - I_____      |
| <input type="checkbox"/> CPR-BLS Certification - E_____   | <input type="checkbox"/> ARC Advanced Swimmer - I_____      | <input type="checkbox"/> ARC Std./Adv. First Aid - E_____  |

Have you ever been convicted of anything other than a minor traffic violation?

YES  NO If yes, please explain: \_\_\_\_\_

The information contained in this form is true and correct to the best of my knowledge:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**REFERENCES FOR SCOUT LEADERS** (THIS IS REQUIRED BY THE SATE OF MICHIGAN!)

As the representative for the chartering organization, I recommend the above identified individual to serve as a leader of our Scouts in camp.

\_\_\_\_\_  
Unit Committee Chair or Head of Chartered Organization

As the representative for the related council, I recommend the above identified individual to serve as a leader of our Scouts in camp.

\_\_\_\_\_  
Unit Commissioner, District Committee Member, Etc.

As an individual who knows the good character of the above identified individual, I recommend him/her to serve as a leader of youth (Scouts) in camp.

\_\_\_\_\_  
Character Reference (not a relative)

My signature below verifies that I have knowledge and understanding of the requirements for reporting suspected cases of child abuse/neglect, as stated in the camp policy dealing with child abuse/neglect.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_