

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

**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**

Regular summer camp activities require a health examination within the past 36 months by a licensed health care practitioner. A High Adventure trip for older boys (13 and above) requires a health examination within the past 12 months.

**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**

**Parent:** 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	P	P	_____	
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 person being evaluated will be attending one 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 medical history with the participant for any interim changes. Explain any "abnormal" evaluations.

- 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:**

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 sections V and VII of this form) must be scheduled by a licensed health-care practitioner. This medical evaluation (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 has suffered a concussion from a head injury.

**Release of Campers from Camp**

Authorization is granted for the release of the aforementioned individual to employees, staff, volunteers and camp staff of Scenic Trails Council, Boy Scouts of America. In addition, only those individuals listed below are authorized to remove the aforementioned individual from the summer camp office during their period of camping. Proof of ID must be shown before release takes place.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

\* Note: Please list spouse above if both parents have not signed authorization below.

**The following authorization is required by the Michigan Department of Social Services pursuant to PA 116 of 1973 and administrative rule 127.(1).**

The health history contained herein is correct so far as I know, and the person herein described has permission to engage in all prescribed activities, except as noted by me and the physician. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by a designated representative of the Boy Scouts of America to authorize emergency medical or surgical treatment, routine, non-surgical medical care, hospitalize, secure proper anesthesia, or to order injection(s) for my son (or daughter). The person herein described is in good health, has all required immunization current, and I assume the health responsibility for the individual.

Date \_\_\_\_\_ Signature \_\_\_\_\_ Valid for 1 year from date signed.  
 Parent or Guardian  
 Date \_\_\_\_\_ Signature \_\_\_\_\_ Valid for 1 year from date signed.  
 Parent or Guardian  
 Date \_\_\_\_\_ Signature \_\_\_\_\_ Valid for 1 year from date signed.  
 Parent or Guardian