

# PERSONAL HEALTH AND MEDICAL RECORD

## CLASS 1 and CLASS 2

Unit and Number \_\_\_\_\_

**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. **Day Camp, Safari, Wolf & Bear Adventure, Twilights, FunFests, Camporees, unit activities, etc**

**CLASS 2 (required once every 36 months for all participants under 40 years of age).** Activity: Resident camp or 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. **Such as Webelos Adventure Camp, Scout Summer Camps, Brownsea, Eagle Camp, etc.**

*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 (3 days and nights). If a copy is not available, a physical examination (using the Class 2 section of this form) must be scheduled by a \*licensed medical 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 suffered a concussion from a head injury.*

\*In addition to examination conducted by medical doctors and doctors of osteopathy, examinations will be recognized if conducted by doctors of chiropractic, physician's assistants, or pediatric nurse practitioners only in states where they may perform physical examinations on students enrolled in public school systems.

**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 1 (PART A) PERSONAL HEALTH & MEDICAL HISTORY

(Annually by all participants) (PART B ON REVERSE SIDE)

To be filled out by parent, guardian, or adult participant. Please print in ink.

Name \_\_\_\_\_ Date of birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  
Name of parent or guardian \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_  
Home address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Business address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Medical Insurance Name Of Company \_\_\_\_\_ Group/Member No. \_\_\_\_\_

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

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_  
Name \_\_\_\_\_ Relationship \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_  
Name of personal physician \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

**IN CASE OF EMERGENCY**, I understand every effort will be made to contact me (if an adult, my spouse or next of kin).

### AUTHORIZATION TO TREAT MINOR / ISSUANCE OF FIREARM / PHOTO USE

Pursuant to California Family Code 6910 — Pursuant to California Penal Code Section 12552

(PLEASE PRINT) Name of Minor \_\_\_\_\_ Unit Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

**The** undersigned does/do hereby authorize (the Director of the Scouting activity) as agent of the undersigned to consent to any X-ray examination, anesthetic, medical, dental or surgical diagnosis or treatment and hospital care for the above minor which is deemed advisable by and to be rendered under the general or special supervision of any physician or surgeon, licensed under the provision of the Medical Practice Act or any dentist licensed under the Dental Practice Act, whether such diagnosis or treatment is rendered at the office of said physician or dentist, at a hospital, Scout Camp, or elsewhere.

**Further** the undersigned consent that the rifle range instructor of the below named Boy Scout Council may furnish a BSA approved firearm/ archery equipment (see Guide to Safe Scouting) to the above minor for the purpose of instruction in the safe handling and shooting of firearms/archery and related activities.

**And** that the above named minor may participate in other activities of the program experience, including but not limited to, swimming, boating, COPE, rock climbing/rappelling,

I understand that promotional pictures may be taken during a camp or activity. I authorize the San Francisco Bay Area Council, Boy Scouts of America, and the National Council, Boy Scouts of America, to use photographs of my child for promotional materials.

**This** authorization will remain in effect while the above minor is enroute to and from, or involved or participating in any Boy Scout program or activity of the San Francisco Bay Area Council, Boy Scouts of America, unless revoked in writing by the undersigned, and delivered to the aforesaid agent.

**Or,** I do not give the above named minor permission to participate in (be specific) \_\_\_\_\_.

PRINT: Father/Guardian \_\_\_\_\_ SIGN \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Date \_\_\_\_\_

PRINT: Mother/Guardian \_\_\_\_\_ SIGN \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Date \_\_\_\_\_

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

## CLASS 1 (PART B)

Check all items that apply, **past or present**, to your health history. Explain any "Yes" answers.

**ALLERGIES:** Food, medicines, insects, plants Yes No Explain: \_\_\_\_\_

<b>GENERAL INFORMATION:</b>	Yes	No		Yes	No		Yes	No
ADHD (Attention-Deficit Hyperactivity Disorder)	( )	( )						
Asthma	( )	( )	Convulsions/seizures	( )	( )	Hemophilia	( )	( )
Cancer/leukemia	( )	( )	Diabetes	( )	( )	High blood pressure	( )	( )
			Heart Trouble	( )	( )	Kidney Disease	( )	( )

Explain: \_\_\_\_\_

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

List any medications to be taken at camp: \_\_\_\_\_ **(attach a medication information form for each med)**

Over the counter pain relievers which may be administered by Scouting activity health officer: Check below and initial permission here: \_\_\_\_\_

( ) Ibuprofen      ( ) Acetaminophen      ( ) Aspirin      ( ) Other over the counter pain relievers

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 _____	_____
Pertussis _____	Rubella _____	_____

## CLASS 2 MEDICAL EVALUATION

(Read additional requirements outlined on front of form.)

Name \_\_\_\_\_ age \_\_\_\_\_

**NOTE TO LICENSED HEALTH-CARE PRACTITIONERS\*:** 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 health history with the participant for any interim changes. **Explain any "abnormal" evaluations.**

**PHYSICAL EXAMINATION** (To be filled out by a licensed health-care practitioner\*)

Height \_\_\_\_\_ Weight \_\_\_\_\_ BP \_\_\_\_\_ / \_\_\_\_\_ Pulse \_\_\_\_\_

VISION: Normal \_\_\_\_\_ Glasses \_\_\_\_\_ Contacts \_\_\_\_\_

HEARING: Normal \_\_\_\_\_ Abnormal \_\_\_\_\_ Explain \_\_\_\_\_

<b>Check Box:</b>	N	Abn		N	Abn		N	Abn
Growth Development	( )	( )	Teeth	( )	( )	Genitalia	( )	( )
Skin	( )	( )	Cardiopulmonary system	( )	( )	Musculoskeletal	( )	( )
HEENT	( )	( )	Hernia	( )	( )	Neurobehavioral	( )	( )

Explain: \_\_\_\_\_

**Limitations**

Activity restrictions \_\_\_\_\_

Diet restrictions \_\_\_\_\_

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

Licensed health-care practitioner\*

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.	(Finding, diagnoses, treatment, instructions, disposition, etc.)	By

PHOTOCOPYING THIS FORM IS PERMITTED

SFBAC 3441 10-4-01

*Rules for acceptance and participation in the program are the same for everyone without regard to race, color, national origin, age, sex or handicap.*