PERSONAL HEALTH AND MEDICAL RECORD
CLASS 1 AND 2

(Copy and distribute as needed)

Class 1 Personal Health and Medical Record is found on the back of the Cub Scout and Boy Scout Application Form. It is used by youth or adults regardless of age for the following types of activities: day camp, overnight camps, hikes, or other programs (including resident camps) THAT DO NOT EXCEED 72 CONSECUTIVE HOURS where the level of activity is similar to that of home or school and where medical care is readily available. It is not to be used where the medical conditions listed for Class 3 Health Form apply. This form should be updated annually and the current Health and Medical summary is attested by parents to be accurate if participant is under 18. Class 1 Personal Health and Medical Record should be carried by tour leader on all trips and outings.

Class 1 and 2 Personal Health and Medical Record is to be used by youth and adults under 40 for the following types of activities: resident camps lasting longer than 72 consecutive hours, backpacking camping or other programs lasting longer than 72 consecutive hours with a level of activity similar to home or school. Medical care is readily available. It is not to be used where the medical conditions listed for Class 3 Health Form apply. Class 1 and 2 requires evidence of a physical examination by a licensed practitioner within 36 months of the end of camp date. Practitioner must either complete the form and sign it, or attach a copy of the examination to it.

Class 3 Personal Health and Medical Record is required for adults 40 and over who will be participating in an activity lasting longer than 72 consecutive hours, or for unit high adventure activities or any activity where the level of activity is greater than home or school and where medical care is not readily available. Class 3 is also required for any youth or adult regardless of age or type of activity when the following medical conditions apply: person is currently under medical care, takes any prescription medication, requires a medically prescribed diet, has had a illness or injury during the past 6 months that has limited activity for a week or more, has ever lost consciousness during physical activity, or suffered a concussion from a head injury. Class 3 requires a physical examination within 12 months of the activity date.

Be sure to make and use copies of completed Personal Health and Medical Records. Keep originals in a safe place. Copies will not be made at camp, and cannot be provided at any later time.

CLASS 1 PERSONAL HEALTH AND MEDICAL HISTORY

(Must be updated annually)

Name ____ Date of birth __________ Age ______ Sex _____

Address ____________________________ City __________________________ ST ______ Zip_________

Parent/guardian name __________________________________ Home phone _______________________

Physician Name ____ Phone ____________________________

Personal Health/Accident Insurance carrier ________________________ policy # _______________________

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

1.Name _______________________________ phone _________________ relationship __________________

2.Name _______________________________ phone _________________ relationship___________________

I give permission for full participation in BSA program, subject to limitations noted herein.

In case of an emergency, I understand every effort will be made to contact me (if an adult, my spouse or next of kin). In the event I cannot be reached, I hereby give my permission to the physician selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child (or for me if an adult).

I also consent to the use of photographs, videotape, voice recordings and written extractions, in whole or part, of the above named individual for the purpose of illustrations, promotion or publications. (Cross out and initial if you do not consent).

Date ________________ Signature ____

Parent or Guardian if for someone under 18 years of age

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

Allergies: Food, medicines, insects, plants Yes ❑ No ❑ Explain: ___________________________________

General Information:	Yes	No		Yes	No		Yes	No
ADHD	❑	❑	Convulsions	❑	❑	Hemophilia	❑	❑
Asthma	❑	❑	Diabetes	❑	❑	High Blood Pressure	❑	❑
Cancer/leukemia	❑	❑	Heart Trouble	❑	❑	Kidney Disease	❑	❑

Explain: ____

List any medications to be taken at camp: ____

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 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 ___________________ B/P _________________ Pulse______________

Lab: Urinalysis (dipstick) ______________________ Albumin _________________ Sugar __________________

VISION: Normal ____________________ Glasses __________________ Contacts ________________________

HEARING: Normal __________________ Abnormal ________________ Explain: ________________________

Check box:	N	Abn		N	Abn		N	Abn
Growth development	❑	❑	Teeth	❑	❑	Genitalia	❑	❑
Skin	❑	❑	Cardiopulmonary	❑	❑	Musculoskeletal	❑	❑
HEENT	❑	❑	Hernia	❑	❑	Neurobehavioral	❑	❑

Explain: ____

Limitations:

Activity Restrictions: ____

Diet Restrictions: ____

Signature: ____ Date: _______________

Licensed health-care practitioner*

Address: _______________________________________ City: _____________________ST: _______ 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.