

PERSONAL HEALTH AND MEDICAL RECORD CLASS 3

I. IDENTIFICATION

Last name _____ First name _____ Initial _____ Date of birth _____
 Address _____ City _____ State _____ Zip _____
 Health/Accident Insurance company name & policy number _____
 IN CASE OF EMERGENCY NOTIFY:
 Name _____ Relationship _____
 Address _____ City _____ State _____ Zip _____
 Home phone _____ Business phone _____
 Personal physician name _____ phone _____
 Religious affiliation _____

III. Parental Statement

Has it ever been necessary to restrict applicants activities for medical reasons? Yes/No Does applicant take medicine regularly or have special care? Yes/No If yes, explain: _____
 To the best of my knowledge, the information on this form is accurate and complete. I request licensed medical practitioner to examine applicant, to give needed immunizations, 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 signature required of applicant is 18 or younger _____

Applicant signature _____
 Date signed _____

VI. MEDICAL HISTORY

Parent (or applicant if 18 or older): Fill in sections I, II, III, IV and VI before seeing licensed medical 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 & year) _____
 Are you aware of any current health problems? Yes _____ No _____
 Now under medical care or taking medicines? Yes _____ No _____
 Has there been any surgery, illness, allergy, or change in health status since last complete physical examination? Yes _____ No _____
 Give dates and full details below for any yes answers. Is there disease of (or past or present history of):

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

Name: _____ Unit #: _____

PERSONAL HEALTH AND MEDICAL RECORD FORM CLASS 3

This form is to be used by any youth or adult who is currently under medical care, taking a prescription medication, requires a medically prescribed diet, has had an illness or injury during the past 6 months that has limited activity for a week or more, or who has ever lost consciousness during physical activity, or suffered a concussion from a head injury. Class 3 is also used by adults 40 and over who will be participating in an activity such as camping that will last longer than 72 consecutive hours and for all participants of high adventure type activities and all Woodbadge participants. This form is not to be used for National Scout Jamboree or High Adventure Base participants. Keep original form for your personal record. Make copies for use at camp. Be sure form is complete and signatures are legible on copies.

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.
- ___ Asthma ___ convulsions ___ Heart trouble ___ contact lenses
- ___ Diabetes ___ Fainting spells ___ Bleeding disorder ___ dentures

IV. Immunizations

Note year of immunization. If disease, put "D" in year.

- Tetanus ___ Diphtheria ___ Pertussis ___
- Measles ___ Mumps ___ Rubella ___
- Polio ___ Chicken Pox ___

V. Licensed Medical 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 _____ MD/DO/DC/PA/RNP
 Licensed medical practitioner circle one

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.

VII. HEALTH EXAMINATION

Licensed Medical 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 (afoot 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.

Vision _____ Hearing _____
 Date _____ Normal _____ Normal _____
 Ht. _____ Wt _____ Glasses _____ Abnormal _____
 B.P. _____ / _____ Pulse _____ Contacts _____

Check 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) _____

Laboratory: urinalysis (dip stick) albumin _____ sugar _____

In case of emergency, I understand every effort will be made to contact me (if an adult, my spouse or next of kin). In the event I (they) 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 or medications 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 in part, of the above mentioned individual for the purpose of illustrations, promotion, or publications.

Date _____ Signature _____

Parent or guardian if under 18 years of age