BSA ANNUAL HEALTH MEDICAL RECORDS

how to properly fill out your medical form

SCOUTING AMERICA HEALTH AND MEDICAL RECORD

- COMPLETE PARTS A THROUGH B OF THE MEDICAL RECORD COMPLETELY. THIS INCLUDES ADULTS, SIBLINGS, FAMILY MEMBERS WHO MAY OR WILL BE OR MIGHT BE ATTENDING ANY CUB SCOUT MEETINGS, EVENTS, ACTIVITIES, ETC.

- ON PAGE B2, BE SURE TO CHECK "YES" AND SIGN YOUR NAME UNDER "ADMINISTRATION OF THE ABOVE MEDICATIONS IS APPROVED FOR YOUTH BY:" WE CAN'T EVEN GIVE THEM A TYLENOL OR BENADRYL WITHOUT A SIGNATURE.

- ONCE COMPLETED, ATTACH A COPY OF YOUR HEALTH INSURANCE CARD - FRONT AND BACK.

- ATTACH A COPY OF YOUR IMMUNIZATION RECORDS FROM YOUR DOCTOR. ADULTS MUST AT LEAST HAVE UP TO DATE TETANUS SHOT.

- THESE RECORDS BECOME PART OF THE MEDICAL BOOKS THE OUTING LEADERS TAKE WITH THEM IN CASE OF EMERGENCIES WHEN ON ANY MEETING, ACTIVITY, EVENT, CAMPOUTS, OVERNIGHT TRIPS, FIELD TRIPS, ETC.

Part A: Informed Consent, Release Agreement, and Authorization

A

Full name: _____ ← Child's Name

Date of birth: _____ ← Birth-date

High-adventure base participants:

Expedition/crew No.: _____

or staff position: _____

FOR SCOUTS

Informed Consent, Release Agreement, and Authorizati

I understand that participation in Scouting activities involves the risk of personal injury, including death, due to the physical, mental, and emotional challenges in the activities offered. Information about those activities may be obtained from the venue, activity coordinators, or your local council. I also understand that participation in these activities is entirely voluntary and requires participants to follow instructions and abide by all applicable rules and the standards of conduct.

In case of an emergency involving me or my child, I understand that efforts will be made to contact the individual listed as the emergency contact person by the medical provider and/or adult leader. In the event that this person cannot be reached, permission is hereby given to the medical provider selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for me or my child. Medical providers are authorized to disclose protected health information to the adult in charge, camp medical staff, camp management, and/or any physician or health-care provider involved in providing medical care to the participant. Protected Health Information/Confidential Health Information (PHI/CHI) under the Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. §§160.103, 164.501, etc. seq., as amended from time to time, includes examination findings, test results, and treatment provided for purposes of medical evaluation of the participant, follow-up and communication with the participant's parents or guardian, and/or determination of the participant's ability to continue in the program activities.

(If applicable) I have carefully considered the risk involved and hereby give my informed consent for my child to participate in all activities offered in the program. I further authorize the sharing of the information on this form with any BSA volunteers or professionals who need to know of medical conditions that may require special consideration in conducting Scouting activities.

With appreciation of the dangers and risks associated with programs and activities, on my own behalf and/or on behalf of my child, I hereby fully and completely release and waive any and all claims for personal injury, death, or loss that may arise against the Boy Scouts of America, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with any program or activity.

I also hereby assign and grant to the local council and the Boy Scouts of America, as well as their authorized representatives, the right and permission to use and publish the photographs/film/videotapes/electronic representations and/or sound recordings made of me or my child at all Scouting activities, and I hereby release the Boy Scouts of America, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with the activity from any and all liability from such use and publication. I further authorize the reproduction, sale, copyright, exhibit, broadcast, electronic storage, and/or distribution of said photographs/film/videotapes/electronic representations and/or sound recordings without limitation at the discretion of the BSA, and I specifically waive any right to any compensation I may have for any of the foregoing.

Every person who furnishes any BB device to any minor, without the express or implied permission of the parent or legal guardian of the minor, is guilty of a misdemeanor. (California Penal Code Section 19915[a]) My

I give permission for m

Check if you do not want your child to use BB devices

☐ **Checking this box indicates you DO NOT want your child to use a BB device.**

NOTE: Due to the nature of programs and activities, the Boy Scouts of America and local councils cannot continually monitor compliance of program participants or any limitations imposed upon them by parents or medical providers. However, so that leaders can be as familiar as possible with any limitations, list any restrictions imposed on a child participant in connection with programs or activities below.

List participant restrictions, if any: ☐ None

_____

List if any RESTRICTIONS

Check if none

I understand that, if any information I/we have provided is found to be inaccurate, it may limit and/or eliminate the opportunity for participation in any event or activity. If I am participating at Philmont Scout Ranch, Philmont Training Center, Northern Tier, Sea Base, or the Summit Bechtel Reserve, **I have also read and understand the supplemental risk advisories, including height and weight requirements and restrictions, and understand that the participant will not be allowed to participate in applicable high-adventure programs if those requirements are not met.** The participant has permission to engage in all high-adventure activities described, except as specifically noted by me or the health-care provider. If the participant is under the age of 18, a parent or guardian's signature is required.

Participant's signature: _____ ← Have Scout sign here if able Date: _____

Parent/guardian signature for youth: _____ ← Adult Signature Date: _____

(If participant is under the age of 18)

Don't forget to date this

Complete this section for youth participants only:

Adults Authorized to Take Youth to and From Events:

You must designate at least one adult. Please include a phone number.

Name: _____ ← Who can pick up your child

Phone: _____ ← Phone Number

Name: _____ ← Who can pick up your child

Phone: _____ ← Phone Number

Adults NOT Authorized to Take Youth to and From Events:

Name: _____ ← Who CANNOT pick up your child

Phone: _____ ← Phone Number

Name: _____ ← Who CANNOT pick up your child

Phone: _____ ← Phone Number

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Part A: Informed Consent, Release Agreement, and Authorization

A

Full name: _____ ADULT'S NAME

Date of birth: _____ Birth-date

High-adventure base participants:

Expedition/crew No.: _____

or staff position: _____

FOR ADULTS

Informed Consent, Release Agreement, and Authorizati

I understand that participation in Scouting activities involves the risk of personal injury, including death, due to the physical, mental, and emotional challenges in the activities offered. Information about those activities may be obtained from the venue, activity coordinators, or your local council. I also understand that participation in these activities is entirely voluntary and requires participants to follow instructions and abide by all applicable rules and the standards of conduct.

In case of an emergency involving me or my child, I understand that efforts will be made to contact the individual listed as the emergency contact person by the medical provider and/or adult leader. In the event that this person cannot be reached, permission is hereby given to the medical provider selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for me or my child. Medical providers are authorized to disclose protected health information to the adult in charge, camp medical staff, camp management, and/or any physician or health-care provider involved in providing medical care to the participant. Protected Health Information/Confidential Health Information (PHI/CHI) under the Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. §§160.103, 164.501, etc. seq., as amended from time to time, includes examination findings, test results, and treatment provided for purposes of medical evaluation of the participant, follow-up and communication with the participant's parents or guardian, and/or determination of the participant's ability to continue in the program activities.

(If applicable) I have carefully considered the risk involved and hereby give my informed consent for my child to participate in all activities offered in the program. I further authorize the sharing of the information on this form with any BSA volunteers or professionals who need to know of medical conditions that may require special consideration in conducting Scouting activities.

With appreciation of the dangers and risks associated with programs and activities, on my own behalf and/or on behalf of my child, I hereby fully and completely release and waive any and all claims for personal injury, death, or loss that may arise against the Boy Scouts of America, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with any program or activity.

I also hereby assign and grant to the local council and the Boy Scouts of America, as well as their authorized representatives, the right and permission to use and publish the photographs/film/videotapes/electronic representations and/or sound recordings made of me or my child at all Scouting activities, and I hereby release the Boy Scouts of America, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with the activity from any and all liability from such use and publication. I further authorize the reproduction, sale, copyright, exhibit, broadcast, electronic storage, and/or distribution of said photographs/film/videotapes/electronic representations and/or sound recordings without limitation at the discretion of the BSA, and I specifically waive any right to any compensation I may have for any of the foregoing.

Every person who furnishes any BB device to any minor, without the express or implied permission of the parent or legal guardian of the minor, is guilty of a misdemeanor. (California Penal Code Section 19915[a]) My

I give permission for m ode BB devices.)

Check if you do not want use BB devices

☐ **Checking this box indicates you DO NOT want your child to use a BB device.**

NOTE: Due to the nature of programs and activities, the Boy Scouts of America and local councils cannot continually monitor compliance of program participants or any limitations imposed upon them by parents or medical providers. However, so that leaders can be as familiar as possible with any limitations, list any restrictions imposed on a child participant in connection with programs or activities below.

List participant restrictions, if any: ☐ **None**

_____

List if any RESTRICTIONS

Check if none

I understand that, if any information I/we have provided is found to be inaccurate, it may limit and/or eliminate the opportunity for participation in any event or activity. If I am participating at Philmont Scout Ranch, Philmont Training Center, Northern Tier, Sea Base, or the Summit Bechtel Reserve, **I have also read and understand the supplemental risk advisories, including height and weight requirements and restrictions, and understand that the participant will not be allowed to participate in applicable high-adventure programs if those requirements are not met.** The participant has permission to engage in all high-adventure activities described, except as specifically noted by me or the health-care provider. If the participant is under the age of 18, a parent or guardian's signature is required.

Participant's signature: _____ Adult Signature Date: _____ Don't forget to date this

Parent/guardian signature for youth: _____ Date: _____

(If participant is under the age of 18)

Complete this section for youth participants only:

Adults Authorized to Take Youth to and From Events:

You must designate at least one adult. Please include a phone number.

Name: _____ Name: _____

Phone: _____ Phone: _____

Adults NOT Authorized to Take Youth to and From Events:

Name: _____ Name: _____

Phone: _____ Phone: _____

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Part B1: General Information/Health History

B1

Full name: _____ ← Full Name

Date of birth: _____ ← Birth-date

High-adventure base participants:
Expedition/crew No.: _____
or staff position: _____

Age: _____ Gender: _____ Height (inches): _____ Weight (lbs.): _____

Address: _____ FILL THIS OUT

City: _____ State: _____ ZIP code: _____ Phone: _____

Unit leader: This is your CUBMASTER Unit leader's mobile #: 818-123-4567

Council Name/No.: Western Los Angeles County Council (WLACC) Unit No.: Pack 175

Health/Accident Insurance Company: Health Insurance Company Policy No.: Write down your Policy Number

ATTACH A COPY OF YOUR HEALTH INSURANCE CARD

In case of emergency, notify the person below:

Name: Emergency Contact #1 Relationship: _____

Address: _____ Home phone: _____ Other phone: _____

Alternate contact name: Emergency Contact #2 Alternate's phone: _____

Health History

READ EACH LINE CAREFULLY
CHECK THE ONES THAT APPLY TO YOU AND EXPLAIN

Do you currently have or have you

Yes	No	Condition	Explain
✓		Diabetes	Last HbA1c percentage and date: 12.0 1/1/2027 Insulin pump: Yes ✓ No ☐
✓		Hypertension (high blood pressure)	e.g. Taking medication
	X	Adult or congenital heart disease/heart attack/chest pain (angina)/ heart murmur/coronary artery disease. Any heart surgery or procedure. Explain all "yes" answers.	
	X	Family history of heart disease or any sudden heart-related death of a family member before age 50.	
	X	Stroke/TIA	
✓		Asthma/reactive airway disease	Last attack date: e.g. May 3030
	X	Lung/respiratory disease	
	X	COPD	
✓		Ear/eyes/nose/sinus problems	e.g. Seasonal Allergies, sinusitis, deviated septum
✓		Muscular/skeletal condition/muscle or bone issues	e.g. muscular dystrophy, osteoporosis, rheumatoid arthritis
✓		Head injury/concussion/TBI	e.g. Concussion, contusion, hematomas, skull fractures
	X	Altitude sickness	
✓		Psychiatric/psychological or emotional difficulties	e.g Anxiety, Depression
✓		Neurological/behavioral disorders	e.g. ADHD, Autism, Tourette's, Dementia
	X	Blood disorders/sickle cell disease	
	X	Fainting spells and dizziness	
	X	Kidney disease	
✓		Seizures or epilepsy	Last seizure date: e.g. September 1952
✓		Abdominal/stomach/digestive problems	e.g. IBS, acid reflux, Celiac Disease
	X	Thyroid disease	
✓		Skin issues	e.g. Eczema
✓		Obstructive sleep apnea/sleep disorders	CPAP: Yes ✓ No ☐
✓		List all surgeries and hospitalizations	Last surgery date: e.g. C-section 1975
✓		List any other medical conditions not covered above	

Part B2: General Information/Health History

B2

Full name: _____ ← Full Name

Date of birth: _____ ← Birth-date

High-adventure base participants:
Expedition/crew No.: _____
or staff position: _____

Allergies/Medications

Do you have an epi-pen? fill this out

DO YOU USE AN EPINEPHRINE AUTOINJECTOR? Exp. date (if yes) _____ ☐ YES ☐ NO

Do you have an inhaler? Fill this out

DO YOU USE AN ASTHMA RESCUE INHALER? Exp. date (if yes) _____ ☐ YES ☐ NO

Are you allergic to or do you have any adverse reaction to any of the following?

Yes	No	Allergies or Reactions	Explain
		Medication	do you have allergies in this category? please explain
		Food	

Yes	No	Allergies or Reactions	Explain
		Plants	do you have allergies in this category? please explain
		Insect bites/stings	

List all medications currently used, including any over-the-counter medications. Do you take any medications?

☐ Check here if no medications are routinely taken. ☐ If additional space is needed, please list on a separate sheet and attach.

Medication	Dose	Frequency	Reason

FILL THIS OUT if you take any medications

Check this if you allow OVER THE COUNTER medication to be given as needed

☐ YES ☐ NO Non-prescription medication administration is authorized with these exceptions: _____

Administration of the above medications is approved for youth by:

_____ / _____

Parent/guardian signature — MD/DO, NP, or PA signature (if your state requires signature)

Sign here if you allow OVER THE COUNTER medication to be given as needed

Bring enough medications in sufficient quantities and in the original containers. Make sure that they are NOT expired, including inhalers and EpiPens. You SHOULD NOT STOP taking any maintenance medication unless instructed to do so by your doctor.

Immunization

COMPLETE THIS SECTION

The following immunizations are recommended. Tetanus immunization is required and must have been received within the last 10 years. If you had the disease, check the disease column and list the date. If immunized, check yes and provide the year received.

Yes	No	Had Disease	Immunization	Date(s)
			Tetanus	ADULTS MUST HAVE CURRENT TETANUS SHOT
			Pertussis	
			Diphtheria	
			Measles/mumps/rubella	
			Polio	PROVIDE COMPLETE VACCINATION INFORMATION
			Chicken Pox	
			Hepatitis A	
			Hepatitis B	
			Meningitis	
			Influenza	
			Other (i.e., HIB)	
			Exemption to immunizations (form required)	exceptions are NO longer accepted

Please list any additional information about your medical history:

any other relevant information to add?

DO NOT WRITE IN THIS BOX.
Review for camp or special activity.

Reviewed by: _____

Date: _____

Further approval required: ☐ Yes ☐ No

Reason: _____

Approved by: _____

Date: _____

ATTACH A COPY OF CHILD'S VACCINATION RECORDS

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