Cub/Webelos Scout _____ Scout/Venturer _____ Adult _____ Camp Staff: Youth____Adult____

PERSONAL HEALTH AND MEDICAL RECORD FORM—CLASS 3

All Class 3 activities require a health examination by a physician within the past 36 months for youth and adults under 40 years of age. Adults 40 and over must have an examination by a physician every 12 months. This includes youth and adult members participating in high-adventure activities, athletic competitions and national or world jamborees.

Name: _____ **Unit:** _____

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.

THIS SECTION TO BE FILLED OUT BY PARENT, GUARDIAN OR ADULT

TO BE FILLED OUT BY PARENT, GUARDIAN, OR ADULT PARTICIPANT. Please print in ink.

Name_____ Age_____ DOB_____ Sex____

Home address/city/zip_____ Home phone_____

Name of parent or guardian_____ Work phone_____ Cell phone/beeper # _____

In an emergency contact:

Name_____ relationship_____ home phone_____ work phone_____

Name_____ relationship_____ home phone_____ work phone_____

Name of personal physician_____ phone_____

Personal health/accident insurance carrier_____ Policy #_____

MEDICAL HISTORY: Parent (or applicant if over 18) Fill in this entire section before seeing a physician. 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, injury, illness, allergy, or change in health status since last complete physical examinations? Yes No

Give year & details below for any "yes" answers or circled to right

Is there disease of (or past or present history of) Circle all that apply and give year.

	Year		Year		Year
Serious illness	_____	Chest, lungs	_____	Menstrual problems	_____
Serious injury	_____	Heart	_____	Hernia (rupture)	_____
Deformity	_____	Murmur	_____	Back, limbs, joints	_____
Surgery	_____	Rheumatic fever	_____	Sleepwalking	_____
Skin, glands	_____	Stomach, bowels	_____	Nervous condition	_____
Ears, eyes	_____	Appendicitis	_____	Emotional problems	_____
Nose, sinus	_____	Kidneys or urine	_____	Behavioral problems	_____
Teeth, tonsils	_____	Albumin	_____	Have you had or do you currently have a contagious or infectious disease? YES NO	
Dentures	_____	Sugar	_____		
Bridge	_____	Infection	_____		
Tuberculosis	_____	Bed-wetting	_____		

Details_____

_____

EMERGENCY MEDICAL INFORMATION: Has or is subject to (circle 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 Dentures Fainting spells Bleeding disorders Other?_____

Explain_____

_____

PARENTAL STATEMENT: Has it ever been necessary to restrict applicant activities for medical reasons? Yes No Does applicant take regular medicine or have special care? Yes No If yes, explain._____

_____

To the best of my knowledge, the information above is accurate and complete. I request physician 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 judgment of medical personnel dictates.

Applicant's Signature_____ Parent or Guardian_____ Date signed_____

(Must sign if applicant is under 18)

THIS SECTION TO BE FILLED OUT BY A LICENSED PHYSICIAN

HEALTH EXAMINATION BY PHYSICIAN: 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 before exam. (top half of this page and attached page)

* Review immunizations for youth (under 18) tetanus and diphtheria toxoids, measles, mumps, and rubella vaccines, and trivalent oral polio vaccine are required; adults and youth are required to have tetanus booster within 10 years.

* After completing this section, summarize any restrictions and/or recommendations in section below and sign.

Ht._____ Wt._____ B..P._____/_____ Pulse_____ VISION: (circle) Normal Glasses Contacts

Check all below and circle if abnormal and give details below: HEARING: (circle) Normal Abnormal

Growth, development	Eyes, ears, nose	Abdomen, hernia, rings	Respiratory
Skin, glands, hair	Teeth, tonsils	Genitourinary	Skeletomuscular
Head, neck, thyroid	Cardiovascular	Neuropsychiatry	Other (specify)_____

Details_____

_____

_____

Laboratory: Urinalysis (dip stick) Albumin_____ sugar_____ (Circle all that apply)

PHYSICIAN'S EVALUATION AND ADVICE: Approved for participation in: Hiking Camping Water Activities Competitive Sports All activities

Specify exceptions_____

Recommendations (explain any restrictions or limitations)_____

_____

Date_____ Signed_____ Phone #_____ M.D./D.O./D.C.P.A./R.N.P. (circle)

TO BE COMPLETED BY CAMP/ACTIVITY MEDICAL OFFICER

REVIEW FOR CAMP OR SPECIAL ACTIVTY:

DATE	AGENCY AND ACTIVITY	BY	"OK"	PHYSICIAN RECHECK NEEDED	RESULTS OF RECHECK	INITIAL

INTERVAL RECORD (CAMP, JAMBOREE, TOURNAMENT, TRAVEL, ETC.)

DATE, TIME, PLACE, ETC.	FINDINGS, DIAGNOSES, TREATMENT, INSTRUCTIONS, DISPOSITION, ETC.	BY:

THIS SECTION TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN

Release of Campers from Camp

(To be completed for youth under 18 years of age)

Authorization is granted for the release of the aforementioned individual to employees, staff, volunteers, and camp staff of Lake Huron Area 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 _____

*Please note: Please list spouse 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 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.

FOR YOUTH ATTENDING CAMP/ACTIVITIES, THIS FORM MUST BE SIGNED EACH YEAR AND AN UPDATED HEALTH HISTORY FORM MUST ACCOMPANY THIS FORM.

*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

NOTE TO PARENTS: ALL MEDICATIONS MUST BE IN ORIGINAL CONTAINERS

2-1-01