GREATER NEW YORK COUNCILS **BOY SCOUTS OF AMERICA**

PERSONAL HEALTH AND MEDICAL RECORD FORM – CLASS 3

Identification Age: _____ Sex _____ Date of Birth

Name: ____ ____/____/____
Last Name First Name Initial Mo. Day Year

Address ____

City ___________________________ State _______ Zip ______________

IN AN EMERGENCY NOTIFY:

Parent: ____________________________ Home:( ) _____-________

Address: ___________________________ Work:( ) _____-________

_______________________________________ Cell: ( ) _____-________

Other Emergency Contact:

Name: ______________________________ Home:( ) _____-________

Work: ( ) _____ - ________ Cell: ( ) _____ - __________

BOY SCOUTS OF AMERICA

All class 3 activities require a health examination within the past 12 months by a licensed health-care practitioner.* This includes youth and adult members participating in high-adventure activities, athletic competition and world jamborees. Annually, this form is to be used by adults over 40 for all activities requiring a physical examination and applies to all Woodbadge participants/staff regardless of age.

EMERGENCY MEDICAL INFORMATION

Has or is subject to (check and give details, use back if needed):

[] Allergy to a medicine, food**, plant, animal or insect toxin

[] Any condition that may require special care, medication or diet

[] ADHD (Attention Deficit Hyperactive Disorder)

[] Asthma [] Convulsion [] Heart trouble [] Contact lenses

[] Diabetes** [] Fainting spells [] Bleeding disorders [] Dentures

Explain: ____

PARENTAL STATEMENT

Has it ever been necessary to restrict applicant's activities for medical reasons? [] Yes [] No Does applicant take medicine regularly or have special care? [] No [] Yes If yes, explain: ______________________________

I have reviewed and to the best of my knowledge, the information in sections I, II, III, IV, and VI, is accurate and complete. I request a licensed health-care practitioner to examine applicant, to give needed immunization and to furnish requested information to other agencies as needed. I give my permission for all 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.

Parent or guardian ______________________________
(must sign if applicant is 18 or younger)

Applicant's signature ______________________________

Date signed ______________________________

IMMUNIZATIONS

If disease, put "D" and year,

	Last date given
Tetanus	___/__/___
Diphthena	___/__/___
Pertussis	___/__/___
Measles	___/__/___
Mumps	___/__/___
Rubella	___/__/___
Polio	___/__/___
Chicken Pox	___/__/___
Hepatitis B	___/__/___
Haemophilus Influenza – B	/ /

Religious preference

GENERAL INFORMATION

This Personal Health & Medical Record is treated as confidential. Medical information may be shared with necessary staff members to insure the health and safety of the applicant.

All prescribed medication must be in the original container and properly labeled by a physician or pharmacist. Ensure enough medication is provided for the length of the applicants stay at camp. All medication left at camp will be destroyed within one week after applicant leaves camp.

Additional Notes:

____

____

Health/Accident Insurance Company:

____

Policy #___________________ ☐ **We do not have insurance**

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. The upper section may be reproduced

IMPORTANT NOTICE FOR ALL CAMPERS ATTENDING A NEW YORK STATE CAMP FOR MORE THAN 7 NIGHTS

New York State legislation passed in 2003 requires all camps to provide information on meningitis to all families of campers who attend camp for more than seven nights. The law also requires parents of these campers to acknowledge receipt of this information and indicate whether or not the camper has been immunized against meningitis.

The required response form must be attached to this form in order for any camper to attend camp for more than seven nights.

If your child will be camping with us for more than seven nights and the information and response form are not attached to this medical record, please contact Camping Services at (212) 651-2955. The information and response form can also be downloaded from tenmileriver.org.

Thank you for your assistance in this important matter regarding your child's health.

FOR CAMP USE ONLY

MEDICAL RE-CHECK

Allergies [] Yes [] No ___________________________________

Restrictions [] Yes [] No ___________________________________

Medications [] Yes [] No ___________________________________

Medical Alert [] Yes [] No ___________________________________

Feels Today ____

New Condition ____

Emergency contact information verified [] ____

Notes:

MEDICAL RE-CHECK

Allergies [ ] Yes [ ] No ___________________________________

Restrictions [ ] Yes [ ] No ___________________________________

Medications [ ] Yes [ ] No ___________________________________

Medical Alert [ ] Yes [ ] No ___________________________________

Feels Today ____

New Condition ____

Emergency contact information verified [ ] __________________________

Notes:

FOR USE AT GREATER NEW YORK COUNCILS CAMPS

HEALTH EXAMINATION

Licensed Health-Care Practitioner:

The applicant will be participating in a strenuous activity that will include one or more of the following: 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.

Review immunizations **(over)**: 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 tetanus booster within ten years. A measles booster is recommended at age 12.

Summarize any restrictions and/or recommendations below, review medication orders, list medication(s) and strike any medication not approved for use and sign.

VISION: **HEARING**:

Date ______________ Normal _________ Normal ____________

Ht. ________________ Glasses _________ Abnormal __________

Wt. ______________ Contacts _________

B.P. ______/______ Pulse ______________

Check box if normal; circle if abnormal & give details below:

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

Comments ____

____

____

LABORATORY: Urinalysis (dip stick) Albumin _________________ Sugar ___________________

LICENSED HEATH-CARE PRACTITIONER'S EVALUATION & ADVICE

Approved for participation in:

[] Hiking and camping [] Water activities

[] Competitive sports [] All activities

Specify exceptions ____

Recommendations (explain any restrictions or limitations): ____

HEALTH-CARE PRACTITIONER MEDICATION ORDERS

Applicant takes the following medication(s):

Med. #1 ______________________ Dosage _________________ Times ______________

Med. #2 ______________________ Dosage _________________ Times ______________

To note additional medications or give more detailed information use section X or attach additional page(s). Identify any medication(s) taken during the school year that applicant does/may not take during the summer.

The camp Medical Officer may give the following over the counter medications as per label instructions based on age and weight. Strike out any medication that should not be given

- •Diphenhybramine USP
- •Chlortrimeton
- •Ivarest Topical
- •Calamine Topical
- •Guiatuss (Robitussin)
- •Novafed
- •Actifed
- •Acetominophen
- •Topical Tinactin Liquid or powder
- •Chloraseptic Gargle (or equivalent)
- •Caladryl Topical
- •Topical Hydrocortisone 0.5% cream
- •Kaopectate
- •Sudafed
- •Ibuprophen
- •Other ________________________

Health Care Providers Name ____

Phone _________________________ **Date** ________________ **Signed** ____

Licensed health-care practitioner

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.

MEDICAL HISTORY

Parent (or applicant if 18 or older): Fill in front sections before seeing a licensed health-care 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) __________ 20____

Are you aware of any current health problems?

[ ] Yes [ ] No

Now under medical care or taking medications?

[ ] Yes [ ] No

Has there been any surgery, injury, illness 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):

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

Revised 1/2009

Please ensure both sides are completed.