



YOUTH HEALTH HISTORY & MEDICAL EVALUATION

THIS FORM IS NOT TO BE USED BY ADULTS.

1. If your child has had a medical evaluation (physical exam) within the last 36 months, a copy of the results of this examination must be attached to the health history portion of this form for all participants in a summer camping experience.
2. If a copy is not available, a physical exam using the medical evaluation section on the back of this form must be performed **this year prior to camp** by a licensed medical practitioner.*
3. A physical exam this year prior to camp is also required if your child is currently under medical care, takes a prescribed medication, requires a medically prescribed diet, has had an injury or illness during the past 6 months that limited activity for a week or more, has ever lost consciousness during physical activity, or suffered a concussion from a head injury.

* 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.

HEALTH HISTORY To be *filled out and signed annually* by parent or guardian.

IDENTIFICATION To be filled out by parent, guardian, or adult participant. Please print in ink.

Name _____ Date of birth _____ Age _____ Sex _____

Name of parent or guardian _____ Telephone _____

Home address _____ City _____ State _____ Zip _____

Business address _____ City _____ State _____ Zip _____

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

Name _____ Relationship _____ Telephone _____

Name _____ Relationship _____ Telephone _____

Name of personal physician _____ Telephone _____

Personal health/accident insurance carrier _____ Policy No. _____

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 | Explain: _____ |
|-----------------------------|--------------------------|--------------------------|---------------------|--------------------------|--------------------------|----------------|
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Heart trouble | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Cancer/leukemia | <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Convulsions/seizures | <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Kidney disease | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

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 _____ _____

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

In case of emergency, I understand every effort will be made to contact me. 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. I give permission for images of my child to be used in print and web publications that promote council camping facilities.

Date _____ **X** _____

Signature of parent or guardian

MEDICAL EVALUATION

Read all requirements outlined on the top of page 1

NAME

Name _____ Age _____

NOTE TO LICENSED MEDICAL PRACTITIONERS*: The person being evaluated will be attending 1 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 medical practitioner)

Height _____ Weight _____ BP _____ / _____ Pulse _____

Lab: Urinalysis (dipstick) _____ Albumin _____ Sugar _____

VISION: Normal _____ Glasses _____ Contacts _____

HEARING: Normal _____ Abnormal _____ Explain _____

| | | | | | | | | | |
|--------------------|--------------------------|--------------------------|------------------------|--------------------------|--------------------------|--------------------------|-----------------|--------------------------|--------------------------|
| Check box: | N | Abn | | N | Abn | | N | Abn | |
| Growth development | <input type="checkbox"/> | <input type="checkbox"/> | | Teeth | <input type="checkbox"/> | <input type="checkbox"/> | Genitalia | <input type="checkbox"/> | <input type="checkbox"/> |
| Skin | <input type="checkbox"/> | <input type="checkbox"/> | Cardiopulmonary system | <input type="checkbox"/> | <input type="checkbox"/> | | Musculoskeletal | <input type="checkbox"/> | <input type="checkbox"/> |
| HEENT | <input type="checkbox"/> | <input type="checkbox"/> | Hernia | <input type="checkbox"/> | <input type="checkbox"/> | | Neurobehavioral | <input type="checkbox"/> | <input type="checkbox"/> |

Explain _____

LIMITATIONS

Activity restrictions _____

Diet restrictions _____

Signature _____ M.D./D.O./D.C./P.A./R.N.P.* Date _____

Address _____ Phone _____

City, State, 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.

| INTERVAL RECORD | SCREENING EXAMINATION | |
|-------------------------|---|----|
| DATE, TIME, PLACE, ETC. | (Findings, diagnoses, treatment, instructions, disposition, etc.) | BY |
| | | |

TROOP

CAMP SITE

A PHOTOCOPY OF THIS FORM IS PERMITTED