



Camp Class 2 Medical Evaluation

Heart of America Council, Boy Scouts of America

Scout's Name _____ Date of Birth _____ Unit # _____

NOTICE TO LICENSED PRACTITIONERS: The person being evaluated will be attending long term camp (5 to 9 days). Activities may include sleeping on the ground, participating in strenuous activities such as hiking, boating, and vigorous group games. Please review the health history on the reverse side, and discuss with the participant/parent. Please explain any abnormal findings.

Height _____ Weight _____

Blood Pressure _____ / _____ Pulse _____

Vision: OD _____ OS _____ OU _____

Hearing: Normal _____ Abnormal _____

Participant wear glasses? Yes ___ No ___ Contacts? Yes ___ No ___

If indicated: CBC/Hemoglobin _____

Urinalysis _____

ITEM/SYSTEM	NL	ABNL	COMMENT
General appearance			
Growth and development			
Head			
Eyes			
Ears			
Nose			
Throat			
Cardiovascular			
Lungs			
Musculoskeletal			
Genital/Hernia			
Neurological			
Integument			

General Assessment _____

Dietary Restrictions _____

Activity Restrictions _____

APPROVED FOR PARTICIPATION IN:

- Hiking and Camping
 Competitive Sports
 Water Activities
 All Activities
 No Activities

Licensed Practitioner* Signature _____

PA or RNP in Collaborative Practice with _____

Date of this Examination _____

Practitioner Address _____

City/State/Zip _____

Telephone Number _____

*Licensed Practitioner means: Physician (MD or DO), Nurse Practitioner (RNP) or Physician's Assistant (PA). If signed by PA or RNP, the name of the MD/DO they are in collaborative practice with must be printed on this form in the space provided.

Unit #

District

Name