

HEART OF AMERICA COUNCIL PERSONAL HEALTH AND MEDICAL RECORD FORM - Class 3

Name _____

PLEASE TYPE OR PRINT - Keep original for your record. Make reproductions for camp use. Be sure parents signature and date are original on reproduced copies.

I. IDENTIFICATION UNIT _____ DIST _____ Age _____ Sex _____

Name _____
 Last name First Name Initial

Date of Birth
 Mo Day Year

Social Security Number _____

Address _____

City & State _____ Zip _____

Health/Accident Insurance _____ Policy # _____

IN AN EMERGENCY NOTIFY:

Name _____ Relationship _____

Address _____ Home Phone _____

City & State _____ Bus. Phone _____

Personal Physician _____ Bus. Phone _____

BOY SCOUTS OF AMERICA

All Class 3 activities require a health examination within the past 12 months by a licensed medical doctor or doctor of osteopathy. 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 and for all activities requiring a physical examination and applies to *all* Wood Badge participants/staff and camp staff regardless of age.

II. EMERGENCY MEDICAL INFORMATION

Has or is subject to (check 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 Fainting Spells Bleeding disorders Dentures

Please list medications and dosages on back.

EXPLAIN _____

III. AUTHORIZATION FOR TREATMENT

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

To the best of my knowledge, the information in sections I, II, III, IV, and VI is accurate and complete. I request licensed Medical Doctor/Doctor of Osteopathy 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.

Parent or guardian _____
 (Must sign if applicant is 18 or younger)

Applicant's signature _____

Date Signed _____

IV. IMMUNIZATIONS

If disease, put "D" and year.

	Last year given
Tetanus	_____
Diphtheria	_____
Pertussis	_____
Measles	_____
Mumps	_____
Rubella	_____
Polio	_____
Chicken Pox	_____

V. LICENSED MEDICAL DOCTOR/DOCTOR OF OSTEOPATHY MEDICAL EVALUATION AND ADVICE

Approved for participation in:

Hiking and camping Water activities
 Competitive Sports All activities

Specify exceptions _____

Recommendations (explain any restrictions OR limitations):

Date _____

Signed _____ M.D./D.O.
 Signed _____ P.A./R.N.P.

if P.A., R.N.P. sign, the M.D./D.O. they are in collaborative practice with must sign above.

VI. MEDICAL HISTORY

Parent (or applicant if 18 or older): Fill in sections I, II, III, IV, and VI *before seeing licensed Medical Doctor/Doctor of Osteopathy.* 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? No Yes
- Now under medical care or taking medicines? No Yes
- Has there been any surgery, injury, illness, allergy, or change in health status since last complete physical examination? No Yes

Give Dates and full details below for any "yes" answers.

IS THERE DISEASE OF (OR PAST OR PRESENT HISTORY OF):

	No	Yes	Year	Details
Serious Illness	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Serious Injury	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Deformity	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Skin, glands	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Ears, eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Teeth, tonsils	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
- Dentures	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
- Bridge	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Chest, Lungs	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Heart	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
- Murmur	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
- Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Stomach, bowels	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Appendicitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Kidneys or urine	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
- Albumin	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
- Sugar	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
- Infection	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
- Bed-wetting	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Menstrual problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hernia (rupture)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Back, limbs, joints	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Sleepwalking	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Nervous condition	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Other (explain)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

VII. HEALTH EXAMINATION

Licensed Medical Doctor/Doctor of Osteopathy:

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 (afloat 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 (VI) before exam.
- Review immunizations; for youth (18 or younger) tetanus and diphtheria toxoid, measles, mumps, and rubella vaccines, and trivalent oral polio vaccine are required; youths and adults must have had tetanus booster within 10 years. A measles booster is recommended at age 12.
- After completing section VII, summarize any restrictions and/or recommendations in sections II and V, above, and sign.

VISION: _____ HEARING: _____

Date _____ Normal _____ Normal _____

Ht. _____ Wt. _____ Glasses _____ Abnormal _____

B.P. _____ / _____ Pulse _____ Contacts _____

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

<input type="checkbox"/> Growth, development	<input type="checkbox"/> Teeth, tonsils
<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Skin, glands, hair
<input type="checkbox"/> Respiratory	<input type="checkbox"/> Skeletomuscular
<input type="checkbox"/> Head, neck, thyroid	<input type="checkbox"/> Cardiovascular
<input type="checkbox"/> Neuropsychiatric	<input type="checkbox"/> Eyes, ears, nose
<input type="checkbox"/> Abdomen, hernia, rings	<input type="checkbox"/> Other (specify)

COMMENTS _____

LABORATORY: Urinalysis (Dip stick)
 Albumin _____ Sugar _____

District _____

Unit # _____

MEDICATIONS, DOSAGE, AND INSTRUCTIONS:
