

Annual BSA Health and Medical Record

Part A

GENERAL INFORMATION

High-adventure base participants:

Expedition/crew No.: _____
 or staff position: _____

Name _____ Date of birth _____ Age _____ Male Female
 Address _____ Grade completed (youth only) _____
 City _____ State _____ Zip _____ Phone No. _____
 Unit leader _____ Council name/No. _____ Unit No. _____
 Social Security No. (optional; may be required by medical facilities for treatment) _____ Religious preference _____
 Health/accident insurance company _____ Policy No. _____

ATTACH A PHOTOCOPY OF BOTH SIDES OF INSURANCE CARD. IF FAMILY HAS NO MEDICAL INSURANCE, STATE "NONE."

In case of emergency, notify:

Name _____ Relationship _____
 Address _____
 Home phone _____ Business phone _____ Cell phone _____
 Alternate contact _____ Alternate's phone _____

HEALTH HISTORY

Are you now, or have you ever been treated for any of the following:

Yes	No	Condition	Explain
		Asthma Last attack: _____	
		Diabetes Last HbA1c: _____	
		Hypertension (high blood pressure)	
		Heart disease (e.g., CHF, CAD, MI)	
		Stroke/TIA	
		Lung/respiratory disease	
		Ear/sinus problems	
		Muscular/skeletal condition	
		Menstrual problems (women only)	
		Psychiatric/psychological and emotional difficulties	
		Behavioral disorders (e.g., ADD, ADHD, Asperger syndrome, autism)	
		Bleeding disorders	
		Fainting spells	
		Thyroid disease	
		Kidney disease	
		Sickle cell disease	
		Seizures Last seizure: _____	
		Sleep disorders (e.g., sleep apnea) Use CPAP: Yes <input type="checkbox"/> No <input type="checkbox"/>	
		Abdominal/digestive problems	
		Surgery	
		Serious injury	
		Other	

Allergies or Reaction to:

Medication _____
 Food, Plants, or Insect Bites _____

Immunizations:

The following are recommended by the BSA. **Tetanus immunization is required and must have been received within the last 10 years.** If had disease, put "D" and the year. If immunized, check the box and the year received.

Yes	No	Date
<input type="checkbox"/>	<input type="checkbox"/>	Tetanus _____
<input type="checkbox"/>	<input type="checkbox"/>	Pertussis _____
<input type="checkbox"/>	<input type="checkbox"/>	Diphtheria _____
<input type="checkbox"/>	<input type="checkbox"/>	Measles _____
<input type="checkbox"/>	<input type="checkbox"/>	Mumps _____
<input type="checkbox"/>	<input type="checkbox"/>	Rubella _____
<input type="checkbox"/>	<input type="checkbox"/>	Polio _____
<input type="checkbox"/>	<input type="checkbox"/>	Chicken pox _____
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A _____
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B _____
<input type="checkbox"/>	<input type="checkbox"/>	Influenza _____
<input type="checkbox"/>	<input type="checkbox"/>	Other (i.e., HIB) _____

Exemption to immunizations claimed (form required).

(For more information about immunizations, as well as the immunization exemption form, see Scouting Safely on Scouting.org.)

MEDICATIONS

List all medications currently used. (If additional space is needed, please photocopy this part of the health form.) Inhalers and EpiPen information must be included, even if they are for occasional or emergency use only.

Medication _____ Strength _____ Frequency _____ Approximate date started _____ Reason for medication _____	Medication _____ Strength _____ Frequency _____ Approximate date started _____ Reason for medication _____	Medication _____ Strength _____ Frequency _____ Approximate date started _____ Reason for medication _____
Medication _____ Strength _____ Frequency _____ Approximate date started _____ Reason for medication _____	Medication _____ Strength _____ Frequency _____ Approximate date started _____ Reason for medication _____	Medication _____ Strength _____ Frequency _____ Approximate date started _____ Reason for medication _____

Administration of the above medications is approved by (if required by your state): _____ / _____
Parent/guardian signature and/or MD/DO, NP, or PA signature

Be sure to bring medications in sufficient quantities and the original containers. Make sure that they are NOT expired, including inhalers and EpiPens. You SHOULD NOT STOP taking any maintenance medication.

Emergency contact No.:

Allergies:

DOB:

Full name:

Part B

INFORMED CONSENT AND HOLD HARMLESS/RELEASE AGREEMENT

High-adventure base participants:

Expedition/crew No.: _____
or staff position: _____

I understand that participation in Scouting activities involves a certain degree of risk and can be physically, mentally, and emotionally demanding. I also understand that participation in these activities is entirely voluntary and requires participants to abide by applicable rules and standards of conduct.

In case of an emergency involving me or my child, I understand that every effort will be made to contact the individual listed as the emergency contact person. In the event that this person cannot be reached, permission is hereby given to the medical provider selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for me or my child. Medical providers are authorized to disclose protected health information to the adult in charge, camp medical staff, camp management, and/or any physician or health care provider involved in providing medical care to the participant. Protected Health Information/Confidential Health Information (PHI/CHI) under the Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. §§160.103, 164.501, etc. seq., as amended from time to time, includes examination findings, test results, and treatment provided for purposes of medical evaluation of the participant, follow-up and communication with the participant's parents or guardian, and/or determination of the participant's ability to continue in the program activities.

I have carefully considered the risk involved and give consent for myself and/or my child to participate in these activities. I approve the sharing of the information on this form with BSA volunteers and professionals who need to know of medical situations that might require special consideration for the safe conducting of Scouting activities.

I release the Boy Scouts of America, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with the activity from any and all claims or liability arising out of this participation.

Without restrictions.

With special considerations or restrictions (list) _____

TALENT RELEASE AGREEMENT

I hereby assign and grant to the local council and the Boy Scouts of America the right and permission to use and publish the photographs/film/videotapes/electronic representations and/or sound recordings made of me or my child at all Scouting activities, and I hereby release the Boy Scouts of America, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with the activity from any and all liability from such use and publication.

I hereby authorize the reproduction, sale, copyright, exhibit, broadcast, electronic storage, and/or distribution of said photographs/film/videotapes/electronic representations and/or sound recordings without limitation at the discretion of the Boy Scouts of America, and I specifically waive any right to any compensation I may have for any of the foregoing.

Yes No

ADULTS AUTHORIZED TO TAKE YOUTH TO AND FROM EVENTS:

You must designate at least one adult. Please include a telephone number.

1. Name _____ Telephone _____

2. Name _____ Telephone _____

3. Name _____ Telephone _____

Adults NOT authorized to take youth to and from events:

1. Name _____

2. Name _____

3. Name _____

I understand that, if any information I/we have provided is found to be inaccurate, it may limit and/or eliminate the opportunity for participation in any event or activity.

If I am participating at Philmont, Philmont Training Center, Northern Tier, or Florida Sea Base: I have also read and understand the risk advisories explained in Part D, including height and weight requirements and restrictions, and understand that the participant will not be allowed to participate in applicable high-adventure programs if those requirements are not met. The participant has permission to engage in all high-adventure activities described, except as specifically noted by me or the health-care provider.

Participant's name _____

Participant's signature _____ Date _____

Parent/guardian's signature _____ Date _____

(if participant is under the age of 18)

Second parent/guardian signature _____ Date _____

(if required; for example, CA)

This Annual Health and Medical Record is valid for 12 calendar months.

Part B Full name: _____ **DOB:** _____

High-adventure base participants:
 Expedition/crew No.: _____
 or staff position: _____

Part C

TO THE EXAMINING HEALTH-CARE PROVIDER (Certified and licensed physicians [MD, DO], nurse practitioners, and physician's assistants)

You are being asked to certify that this individual has no contraindication for participation in a Scouting experience. For individuals who will be attending a high-adventure program at one of the national high-adventure bases, please refer to Part D for additional information.

(Part D was made available to me. Yes No)

PHYSICAL EXAMINATION

Height (inches) _____ Weight (pounds) _____ Maximum weight for height _____ Meets height/weight limits Yes No
 Blood pressure _____ Pulse _____ Percent body fat (optional) _____

If you exceed the maximum weight for height as explained on this page and your planned high-adventure activity will take you more than 30 minutes away from an emergency vehicle-accessible roadway, you **will not** be allowed to participate. At the discretion of the medical advisors of the event and/or camp, participation of an individual exceeding the maximum weight for height may be allowed if the body fat percentage measured by the health-care provider is determined to be 20 percent or less for a female or 15 percent or less for a male. (Philmont requires a water-displacement test to be used for this determination.) Please call the event leader and/or camp if you have any questions. Enforcing the height/weight guidelines is strongly encouraged for all other events.

	Normal	Abnormal	Explain Any Abnormalities	Range of Mobility	Normal	Abnormal	Explain Any Abnormalities
Eyes				Knees (both)			
Ears				Ankles (both)			
Nose				Spine			
Throat							
Lungs							
Neurological				Other	Yes	No	
Heart				Contacts			
Abdomen				Dentures			
Genitalia				Braces			
Skin				Inguinal hernia			Explain
Emotional adjustment				Medical equipment (i.e., CPAP, oxygen)			
Tuberculosis (TB) skin test (if required by your state for BSA camp staff) <input type="checkbox"/> Negative <input type="checkbox"/> Positive							

Allergies (to what agent, type of reaction, treatment): _____

Restrictions (if none, so state) _____

EXAMINER'S CERTIFICATION

I certify that I have reviewed the health history and examined this person and find no contraindications for participation in a Scouting experience. This participant (with noted restrictions above)

True False

- Meets height/weight requirements
- Does not have uncontrolled heart disease, asthma, or hypertension
- Has not had an orthopedic injury, musculoskeletal problems, or orthopedic surgery in the last six months or possesses a letter of clearance from their orthopedic surgeon or treating physician
- Has no uncontrolled psychiatric disorders
- Has had no seizures in the last year
- Does not have poorly controlled diabetes
- If less than 18 years of age and planning to scuba dive, does not have diabetes, asthma, or seizures

Provider printed name _____

Address _____

City, state, zip _____

Office phone _____

Signature _____

Date _____

Height (inches)	Recommended Weight (lbs)	Allowable Exception	Maximum Acceptance
60	97-138	139-166	166
61	101-143	144-172	172
62	104-148	149-178	178
63	107-152	153-183	183
64	111-157	158-189	189
65	114-162	163-195	195
66	118-167	168-201	201
67	121-172	173-207	207
68	125-178	179-214	214
69	129-185	186-220	220
70	132-188	189-226	226
71	136-194	195-233	233
72	140-199	200-239	239
73	144-205	206-246	246
74	148-210	211-252	252
75	152-216	217-260	260
76	156-222	223-267	267
77	160-228	229-274	274
78	164-234	235-281	281
79 & over	170-240	241-295	295

This table is based on the revised Dietary Guidelines for Americans from the U.S. Dept. of Agriculture and the Dept. of Health & Human Services.

DO NOT WRITE IN THIS BOX

REVIEW FOR CAMP OR SPECIAL ACTIVITY

Reviewed by _____ Date _____

Further approval required Yes No Reason _____

By _____ Date _____

Part C Full name: _____ **DOB:** _____

COMPLETE IF YOUNGER THAN 18YRS - STATE OF MICHIGAN REQUIRED AUTHORIZATION

The Michigan Department of Consumer and Industry Service pursuant to public Act 116 of 1973 and Administrative Rule 117.(2)(a) REQUIRES the following information.

Authorization is granted for the release of the aforementioned individual to adult employees, camp staff, and volunteers of the LaSalle Council, Boy Scouts of America. In addition, to the parents and guardians signing this form, only those individuals listed below are authorized to remove the aforementioned individual from summer camp during their period of camping.

Please list spouse below if both parents have not signed the authorization.

Name _____	Relationship _____
Name _____	Relationship _____
Name _____	Relationship _____

THE REMAINDER OF THIS FORM MUST BE COMPLETED BY ALL THOSE 21 AND OLDER

Please read the following State of Michigan Youth Protection Laws and sign below. Thank you!

Pursuant to the provision STATE OF MICHIGAN AND THE BOY SCOUTS OF AMERICA, all leaders at Tamarack are required to report all suspected cases of Child Abuse/Neglect to their Camp Director. They are also to sign a statement that they have knowledge and understanding of the reporting requirements. The Wood Lake Scout Reservation recognizes the intent of the Michigan State Law (Public Act #116 of 1973) and Administrative Rules (#113, #115, #119) in its attempt to ensure the health and the general welfare of its campers.

RULE 113 Discipline is the responsibility of the unit leader. If you need help, consult your Commissioner and/or Camp Director. Vandalism or injury to others will not be tolerated. Rule #113 of "Rules for licensing of Children's Camp in the State of Michigan" reads, "A camper shall not be deprived of food or sleep, be placed alone without staff supervision, observation and interaction, or be subject to ridicule, threat, corporal punishment, or excessive physical exercise, or excessive restraints by another camper or staff member." HAZING OR INTIATION IS STRICTLY PROHIBITED.

RULE 115 It is mandatory that any staff member or volunteer report to his or her Director any actual or suspected case of Child Abuse or Neglect immediately. The Director shall immediately contact the Camp Director, who if after the investigation he finds abuse or neglect, shall by phone report within 24 hours to the Department of Social Services and file a written report within 72 hours. THIS IS THE RESPONSIBILITY OF ALL STAFF MEMBERS AND VOLUNTEER LEADERS.

Reporting Procedures: For abuse taking place in Michigan call Kenneth Phelps, 1-231-873-7012.
For abuse found in Michigan but taking place in Illinois, call the DCFS hotline, 1-800-252-2873.

RULE 119 Each staff member and volunteer must be alert at all times to each camper's physical state, any observed change should be reported to the Director for appropriate action.

The Tamarack procedure for reporting suspected cases of Child Abuse/Neglect follows. This outlines the procedures for you reporting suspected cases of Abuse and Neglect.

PROCEDURES FOR REPORTING SUSPECTED CASES OF CHILD ABUSE/NEGLECT

1. All camp personnel shall be aware of and guided by Department of Social Services Rule #113, #115, and #119 as printed above.
2. Any camp personnel having reasonable cause to believe that any camper's with whom they have had direct contact has been subjected to Abuse or Neglect shall immediately report the matter to their Camp Director/Supervisor.
3. The Camp Director/Supervisor may consult with the appropriate personnel, evaluate the case, make a record of the report, and SHALL REPORT the incident to the DIRECTOR.
4. The DIRECTOR shall report the matter by telephone within 24 hours to the Department of Social Service.
5. All reports shall be confirmed in writing to the Department of Social Service within 72 hours of the report.
6. Any leader who makes a report shall cooperate with the assigned investigation agency, including full testimony in any judicial proceeding resulting from such report, as to any evidence of Abuse or Neglect, or the case thereof.

All persons must sign this statement that they have knowledge and understanding of the Child Abuse/Neglect reporting requirements. All leaders and staff are required to report suspected cases of Child Abuse/Neglect per these guidelines.

My signature below verifies that I have knowledge and understanding of the requirement for reporting suspected cases of Child Abuse/Neglect.

NAME _____
(print)

NAME _____ WEEK _____ DATE _____
(signature)

CAMP _____ TROOP # _____ SITE # _____

Please list previous camp experience:

Special skills, qualifications, or talents:

Any Infectious Diseases? Yes _____ NO _____

If Yes - Explain: _____

BSA REGISTRATION: UNIT _____ COUNCIL _____ EXPIRATION date _____

The following information is REQUIRED by the Michigan Department of Consumer and Industry Services pursuant to public Act 116 of 1973 and Administrative Rule 109.(4):

Camp Staff Member (Leader) Name _____

Registered Position in Council _____

Position in Camp _____

Please indicate training received and date issued:

CPR BLS Certified _____	Safety Afloat Training _____
BSA Life Guard _____	Safe Swim Defense Training _____
ARC Basic Water Safety _____	AGR First Aid Prof Rescue _____
ARC Advanced Swimmer _____	ARC Life Guard Instructor _____
ARC Water Safety Instructor _____	Youth Protection Training _____
ARC First Aid _____	Hazardous Weather Training _____
ARC Life Guard _____	

Have you ever been convicted of anything other than a minor traffic violation? YES _____ NO _____

If yes, please explain: _____

The information contained in this form is correct to the best of my knowledge.

Date: _____ Signed, _____, leader/staff member.

REFERENCES (must be completed prior to camp)

As a representative for the above individual's unit, I recommend him/her to serve as leader/staff at Camp Tamarack, Wood Lake Scout Reservation.

(Character Reference Signature of registered adult from individual's unit) (print name) (date)

Knowing the good character of the above-mentioned individual, I recommend him/her to serve as a leader/staff member at Camp Tamarack, WLSR.

(Character reference signature #1) (print name) (date)

Knowing the good character of the above-mentioned individual, I recommend him/her to serve as a leader/staff member at Camp Tamarack, WLSR.

(Character reference signature #2) (print name) (date)