

Staple here: Immunization Record

PLEASE TYPE OR PRINT.

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. This upper section may be reproduced and carried with you for emergency identification and care.

**PERSONAL HEALTH AND MEDICAL RECORD FORM—Class 3**

**I. IDENTIFICATION** Age \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth\* \_\_\_\_\_  
 Name \_\_\_\_\_ Last name First name Initial \_\_\_\_\_  
 Address \_\_\_\_\_  
 City & State \_\_\_\_\_ Zip \_\_\_\_\_  
 Health/Accident insurance \_\_\_\_\_ Policy no. \_\_\_\_\_

**IN AN EMERGENCY NOTIFY:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
 Address \_\_\_\_\_ Home phone \_\_\_\_\_  
 City & State \_\_\_\_\_ Business phone \_\_\_\_\_  
 Personal Physician \_\_\_\_\_ Phone \_\_\_\_\_

**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 Wood Badge participants/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  
 ADHD (Attention Deficit Hyperactive Disorder)  
 Asthma  Convulsions  Heart trouble  Contact lenses  
 Diabetes †  Fainting spells  Bleeding disorders  Dentures

**EXPLAIN** \_\_\_\_\_

**III. PARENTAL STATEMENT**

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 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 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**

**Parents:**  
 Please attach school immunization record, including Hepatitis B, effective Fall 2001 [month/year] to physical form.

Religious preference \_\_\_\_\_

**V. LICENSED HEALTH-CARE PRACTITIONER'S EVALUATION AND ADVICE**

Approved for participation in:

Hiking and camping  Water activities  
 Competitive sports  All activities

Specify exceptions \_\_\_\_\_

Recommendations (explain any restrictions OR limitations): \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_  
 \*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.

**Practitioner: Please Fill out back side.**

**VI. MEDICAL HISTORY**

Parent (or applicant if 18 or older): Fill in sections I, II, III, IV, and VI 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 and year) \_\_\_\_\_ 19 \_\_\_\_\_
- 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/Medicines
Serious illness	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Serious injury	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Deformity	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Skin, glands	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Ears, eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Nose, sinus	<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"/>	_____	_____

Please list ALL medications taken in the 30 days prior to arrival at the Scouting activity where this form is to be used.

**VII. HEALTH EXAMINATION**

Licensed Health-Care Practitioner: \_\_\_\_\_

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 aloft) 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 toxoids, 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.

Date \_\_\_\_\_ VISION: \_\_\_\_\_ HEARING: \_\_\_\_\_  
 Normal \_\_\_\_\_ Normal \_\_\_\_\_  
 Ht. \_\_\_\_\_ Wt. \_\_\_\_\_ Glasses \_\_\_\_\_ Abnormal \_\_\_\_\_  
 B.P. \_\_\_\_\_ / \_\_\_\_\_ Pulse \_\_\_\_\_ Contacts \_\_\_\_\_

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

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

**COMMENTS** \_\_\_\_\_

**ADULT IMMUNIZATIONS: Please list month/year for:**

Tetanus: \_\_\_\_/\_\_\_\_; Hepatitis B: \_\_\_\_/\_\_\_\_;  
 Measles: \_\_\_\_/\_\_\_\_; Mumps: \_\_\_\_/\_\_\_\_; Diphtheria: \_\_\_\_/\_\_\_\_  
 Disease: Chicken Pox: Yes or No

Date/Parents Initials: Year 1 \_\_\_\_\_ Year 2 \_\_\_\_\_ Year 3 \_\_\_\_\_

# FINGER LAKES COUNCIL BSA

Medications (Dosage and Frequency): Please note that you must bring all medications in **ORIGINAL BOTTLES** with specific directions.

_____	_____
_____	_____
_____	_____

The following is a list of over-the-counter medications available for dispensing at camp. Please indicate with a check mark if this patient may receive these medications.

- Caldecort/Cortison cream to affected area PRN minor pain or discomfort.
- Acetaminophen 15mg/kg Q4hr PRN temp<101 F, minor pain or discomfort.
- Ibuprofen 200mg-400mg Q4-6hr PRN minor pain or discomfort.
- Robitussin 1-2 Tsp PO Q6-8hr PRN coughing.
- Benadryl Elixer/Tab 12.5-25mg PO Q6-8hr (5mg/kg/24hr) PRN not to exceed 300mg/24hr, minor allergic reaction.
- Chloraseptic Spray PO Q2-4hr PRN minor throat discomfort.
- Neosporin/Bacitracin Antibiotic Ointment apply topically to affected area PRN minor cuts/abrasions.
- Caladryl/Calahist lotion topically to affected area PRN minor itching.
- Kaopectate 30-60 ml after each loose BM, not to exceed 6 doses/day or a period <48hrs. Notify physician after 48 hours.
- "After Bite" (Ammonium Hydroxide) apply topically to insect bites PRN itching.
- A & D Ointment to affected area PRN minor skin irritation.

**\*NOTE:** If there are any changes in medications or other medical information after this form is submitted, please notify the camp in writing.

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I recommend this child for the camp program believing that he will benefit from the camp experience and will not endanger or be endangered by the group and its activities.

Physician's/Practitioner's Signature: \_\_\_\_\_ Date \_\_\_\_\_

**PLEASE PRINT**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_