ADULT and SUMMER CAMP STAFF HEALTH & MEDICAL RECORD

Note: The Boy Scouts of America **requires** that adults (under 40) participating in any long-term camping experience (more than 72 hours):
a. MUST have a medical evaluation by a licensed medical provider within **36 months** of the camping experience.
b. MUST have a health history completed within **12 months** of the camping experience.
c. **Adults 40 and over**- must have medical evaluation and health history completed every **12 months**.

Name ____ Date of Birth_____________ Age_______
Last Name First Name Initial

Street Address____City_____________________ State_____

Medical Provider ____ Provider Phone (___)_____________

Family Health/Accident Insurance______________________________ Policy No. ____________________

IN CASE OF EMERGENCY, NOTIFY:

Name ____ AM Phone (____)_______________

Street Address____ PM Phone (____)_______________

City___________________________________ State_______ Zip___________ Pager________________

Alternate____________________________ Phone (_____)_____________ Relationship________________

Alternate____________________________ Phone (_____)_____________ Relationship________________

In the event that I am injured and rendered unconscious, I hereby give permission to the medical provider selected by a designated representative of the Boy Scouts of America to authorize emergency medical surgical treatment, routine, non-surgical medical care, hospitalization, proper anesthesia and/or medication(s)/ injections(s). I assume health and financial responsibility for myself.

____ _____________________
Signature Date

TO BE COMPLETED BY A LICENSED MEDICAL PROVIDER

Check box if NORMAL: Circle if ABNORMAL and give details below:

______ GI ______ Endocme ______ Genitourinary
______ Skin, glands, hair ______ Respiratory ______ Skeletomuscular
______ Head, neck, thyroid ______ cardiovascular ______ Neuropsychiatries
______ Eyes, ears, nose ______ Abdomen, Hernia ______ Other (specify)

HT.___________________ WT.__________________ B./P. _______/________ PULSE_____________

I certify that I have examined _______________________________________ on ________________________
Adult's Name Date of Exam
and find him/her physically fit to participate in all Scouting activities **EXCEPT** as noted below. The aforementioned individual has all immunizations as required by the State of Michigan.

Comments:____

Restrictions/Limitations: ____

Medical Provider name:____

Medical Provider Signature____

Medical Provider phone number (____)______________________________

Campsite______ Team #______ Crew #______ Troop #______ Pack #______ Name______

ADULT HEALTH HISTORY (To completed by Adult)

IF YES IS CHECKED, PLEASE GIVE FULL DETAILS

***HAVE OR SUBJECT TO**: (Check if YES) **IF NONE**: Check here ____

______ Heart Problems _____Asthma ****** Uses an Inhaler No_____ Yes_____
______ Seizure Disorder _____ Diabetes ***** Uses Insulin No_____ Yes_____
______ Kidney Disorder _____ Behavioral/Emotional Concerns______________________________
______ Medication Allergies: List____
______ Food Allergies: List____
______ Seasonal Allergies: List____
______ Stinging Insect Reaction: Treatment____
______ Other health Concern(s) ____

***HAVE DIFFICULTY WITH**: (Check if YES) **IF NONE:** Check here ______

______ Tires easily ______ Muscle Fatigue ______ Ear Infections
______ Breathing ______ Nose Bleeding ______ Sinus Infections
______ Stomach/Bowels ______ Sleeping ______ Athletes Foot
Explain: ____

***CURRENT HEALTH STATUS**: (Check if YES) **IF NONE**: Check here ______

______ Currently under medical care. Explain: ______________________________
______ Currently taking any medications. Complete CURRENT MEDICATION SECTION____
______ Serious illness/injury in past year. Explain: ______________________________
______ Current ear, nose or throat infection. Explain: ______________________________
______ Current cold or seasonal allergy. Explain: ______________________________
______ Current behavioral/emotional concerns. Explain: ______________________________
______ Dental Concerns Explain: ______________________________
______ Diet restrictions. Explain: ______________________________
______ Activity restrictions. Explain: ______________________________
______ Wears contacts
______ Other current health concerns. Explain: ______________________________
____

THE FOLLOWING IMMUNIZATIONS ARE CURRENT AND UP TO DATE:

_____ MMR (measles, mumps, rubella), _____ DPT (diphtheria, pertussis, tetanus),
_____ Polio, Smallpox, Varicella (Chicken Pox) ______ Negative TB Test of Chest x-ray (**STAFF ONLY**)
_____Tetanus Booster

CURRENT MEDICATIONS: (Prescription & Non-Prescription)

____I take **NO** medications on a routine basis.

I take the following medications on a regular basis.

Med. #1 ______________________ Dosage ________ Times to be given________________
Reason for taking above medication: ____

Med. #2 ______________________ Dosage ________ Times to be given________________
Reason for taking above medication: ____

Attach additional pages for more medications.

Signature (1st year)____________________________________ Date______________

Signature (2nd year)____________________________________ Date ______________

Signature (3rd year)____________________________________ Date______________