

BOY SCOUT YOUTH HEALTH & MEDICAL RECORD

Parent/Guardian:

The Boy Scouts of America requires that youth 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 by parent or guardian within 12 months of the camping experience.

Name of Youth Last Name First Name Initial Date of Birth Age

Youth Home Address City State

Medical Provider (Youth) Provider Phone

Family Health/Accident Insurance Policy No.

IN CASE OF EMERGENCY, NOTIFY:

Name of parent/Guardian AM Phone

Home Address PM Phone

City State Zip Pager

Alternate Phone Relationship

Alternate Phone Relationship

YOUTH HEALTH HISTORY (To completed by Custodial Parent/Guardian)

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 Explain:
Other current health concerns. Explain:

THE FOLLOWING IMMUNIZATIONS ARE CURRENT AND UP TO DATE: (MUST indicate last inoculation dates(s):

MMR (measles, mumps, rubella), DPT (diphtheria, pertussis, tetanus),
Polio, Smallpox, Varicella (Chicken Pox) other
Tetanus Booster

Campsite

Team #

Crew #

Troop #

Pack #

Name

CURRENT MEDICATIONS: (Prescription & Non-Prescription) Attach additional pages for more medications.

My son (daughter) takes **NO** medications on a routine basis.

My son (daughter) takes 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: _____

Med #3 _____ Dosage _____ Times to be given _____

Reason for taking above medication: _____

I (we) give permission for my our son to receive the following over the counter medications as determined necessary by an authorized BSA employee, camp staff or volunteer for purposes of First Aid and Safety:

_____ **NONE** _____ Pain/Fever relievers _____ Antihistamines _____ Anti-diarrheas

_____ Anti-acids _____ Cough/Cold meds _____ Topical Antibiotics & Anti-itch Ointments

_____ Other _____

Custodial parent/Guardian Signature: _____ Date _____

TO BE COMPLETED BY A LICENSED MEDICAL PROVIDER

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

_____ Growth, Development _____ Teeth, Tonsils _____ Genitourinary
_____ Skin, glands, hair _____ Respiratory _____ Skeletomuscular
_____ Head, neck, thyroid _____ cardiovascular _____ Neuropsychiatry
_____ Eyes, ears, nose _____ Abdomen, Hernia _____ Other (specify)

HT. _____ WT. _____ B./P. _____ / _____ PULSE _____

I certify that I have examined _____ on _____
Youth 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 required immunizations as required by the State of Michigan.

Comments: _____

Restrictions/Limitations: _____

Provider Signature _____ Provider name: _____

Provider phone number () _____

STATE OF MICHIGAN REQUIRED AUTHORIZATIONS

The Michigan Department of Consumer and Industry Services pursuant to Public Act 116 of 1973 and administrative Rule 127.1(1) REQUIRES the following authorization:

- The person herein described is in **GOOD HEALTH** and has all required immunizations. The information and health history contained herein is accurate and complete. Permission is granted for full participation in BSA programs and activities, subject to limitations noted herein. In the event I (we) cannot be reached in emergency, I (we) hereby grant permission to the medical provider selected by BSA representatives to authorize emergency medical/surgical treatment, routine non-surgical medical care, hospitalization, proper anesthesia and/or medications(s)/injections(s) for my (our) son (daughter). I (we) assume health & financial responsibility for the aforementioned individual.

Date _____ Parent Signature (1st year) _____ Print _____

Date _____ Parent Signature (2nd year) _____ Print _____

Date _____ Parent Signature (3rd year) _____ Print _____

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 Southwest Michigan 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.

Name _____ Relationship _____

Name _____ Relationship _____