

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

**I. IDENTIFICATION** Age \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth\*  
 Name \_\_\_\_\_  
 Last name First name Initial Mo. Day Year  
 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 \_\_\_\_\_

**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 \_\_\_\_\_  
 Updated \_\_\_\_\_ Signed \_\_\_\_\_ Parent or guardian  
 Updated \_\_\_\_\_ Signed \_\_\_\_\_ Parent or guardian

**IV. IMMUNIZATIONS**  
 If disease, put "D" and year. Last year given  
 Tetanus \_\_\_\_\_  
 Diphtheria \_\_\_\_\_  
 Pertussis \_\_\_\_\_  
 Measles \_\_\_\_\_  
 Mumps \_\_\_\_\_  
 Rubella \_\_\_\_\_  
 Polio \_\_\_\_\_  
 Chicken Pox \_\_\_\_\_

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

**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 40 years of age or older 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 \_\_\_\_\_

**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): \_\_\_\_\_  
 \_\_\_\_\_  
 Date \_\_\_\_\_  
 Signed \_\_\_\_\_  
 \*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.

**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.

**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) \_\_\_\_\_ 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/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 onfoot) 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.

VISION: \_\_\_\_\_ HEARING: \_\_\_\_\_  
 Date \_\_\_\_\_ 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**  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**FOR THOSE ATTENDING PHILMONT OR NATIONAL HIGH-ADVENTURE BASES:**  
 \* The minimum age for all participants is 13 by January 1 of the year of participation, or have completed the seventh grade. No exceptions.  
 † Trail food is by necessity a high-carbohydrate, high-calorie diet. It is high in wheat, milk products, sugar, corn syrup, and artificial coloring/flavoring. Dinner meals contain meat. If these food products cause a problem in your diet, you need to bring appropriate substitutions with you and so advise base personnel.  
**Note:** Licensed health-care practitioners representing high-adventure bases reserve the right to deny access to the trails or other program activity on the basis of a medical evaluation performed at the base after arrival.

**REVIEW FOR CAMP OR SPECIAL ACTIVITY**

DATE	Agency and Activity	By	"OK"	Physician Recheck Needed	Results of Recheck	Initial

**INTERVAL RECORD (CAMP, JAMBOREE, TOURNAMENT, TRAVEL, ETC.)**

Date	Time	Place	Findings, Diagnoses, Treatment, Instructions, Disposition, etc.	By:

**INSURANCE INFORMATION (Insurance information is valid from \_\_\_\_\_ to \_\_\_\_\_)**

Insurance Company:			
Policy Number:		Group Number:	
Policy Holder:		Policy Holder's D.O.B.:	

I give permission for the Health Lodge Officer/First Aid Staff to dispense the following Over-The-Counter medications (brand name or generic) to my son/daughter as needed and at the recommended dosage. These medications are available at the Health Lodges at Akelaland, Settlers Camp, and Camp Minsi.

**PARENT'S SIGNATURE:** \_\_\_\_\_

Medication	Yes	No	Medication	Yes	No
Advil (tablets/caplets)			Milk of Magnesium (M.O.M.)		
Advil (liqui-gel)			Tums		
Tylenol (tablets/caplets)			Imodium A-D		
Tylenol (gel caps)			Robitussin-DM (cough, congestion)		
Children's Tylenol (chewables)			Children's Dimetapp-DM		
Children's Tylenol (liquid)			Children's Dimetapp-Elixir		
Benedryl (tablets)			Pepto Bismol (chewables)		
Benedryl (liquid)			Pepto Bismol (liquid)		

**FOR ALL CAMPER AND LEADERS UNDER AGE 40**

THIS MEDICAL FORM IS GOOD FOR 3 YEARS. THE FIRST YEAR IT MUST BE COMPLETED BY A PHYSICIAN AND SIGNED BY THE DOCTOR, A PARENT OR LEGAL GUARDIAN (IF UNDER AGE 18), AND THE CAMPER. THE SECOND AND THIRD YEARS MUST BE SIGNED BY A PARENT OR LEGAL GUARDIAN (IF UNDER AGE 18) AND THE CAMPER IN THE BLOCKS BELOW, PROVIDED THERE HAS BEEN NO CHANGES IN THE HEALTH INFORMATION AS LISTED ON THE FRONT.

**FOR ADULTS OVER 40 AND ALL STAFF MEMBERS, BOTH PAID AND VOLUNTEER**

THIS FORM MUST BE FILLED OUT EACH AND EVERY YEAR YOU COME TO CAMP. THIS IS TRUE NO MATTER WHAT LENGTH OF TIME YOU ARE SPENDING AT CAMP.

PARENTAL STATEMENT	2 <sup>nd</sup> Year Parental Statement		3 <sup>rd</sup> Year Parental Statement	
Has it ever been necessary to restrict applicant's activities for medical reasons?	YES	NO	YES	NO
Does applicant take regular medicine or have special care?	YES	NO	YES	NO
To the best of my knowledge the information in sections I, II, III, IV, and VI is accurate and complete. I request physician to examine applicant to give needed immunization, and to furnish requested information to other agencies as needed. I give 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'S OR LEGAL GUARDIAN'S SIGNATURE	2 <sup>nd</sup> Year Parental Statement		3 <sup>rd</sup> Year Parental Statement	
APPLICANT'S SIGNATURE				
DATE SIGNED				