Annual BSA Health and Medical Record Part A General Information			al Record	Expedition/crew No.:	High-adventure base participants: Expedition/crew No.: or staff position:		
					Age Male 🗆 Fema		
					Grade completed (youth only)		
City State							
					Unit No		
	•				Religious preference		
lealth/a	accident	t insurance company		Policy	/ No		
	ATTAC	H A PHOTOCOPY OF BOTH	SIDES OF INS	SURANCE CARD. IF FAMILY HAS	NO MEDICAL INSURANCE, STATE "NONE."		
n case d	of emer	gency, notify:					
lame _				Relationship			
Address	5			· ·			
					Cell phone		
					's phone		
				Alternate	s priore		
IEALTH							
Are you	now, or	r have you ever been treated for	or any of the to	bllowing:	Allergies or Reaction to:		
Yes	No	Condition		Explain	Medication		
		Asthma Last attack:			Food, Plants, or Insect Bites		
		Diabetes Last HbA1c:					
		Hypertension (high blood pre	essure)		Immunizations:		
		Heart disease (e.g., CHF, CA	D, MI)		The following are recommended by the BS		
		Stroke/TIA			Tetanus immunization is required and m		
		Lung/respiratory disease			have been received within the last 10 yea		
		Ear/sinus problems			had disease, put "D" and the year. If immun check the box and the year received.		
		Muscular/skeletal condition			Yes No Date		
		Menstrual problems (womer	n only)		res No Date D Tetanus		
		Psychiatric/psychological and					
		emotional difficulties			□ □ □ Diphtheria		
		Behavioral disorders (e.g., A ADHD, Asperger syndrome,			□ □ Measles		
		Bleeding disorders					
		Fainting spells			□ □ Rubella		
		Thyroid disease			Delio		
		Kidney disease			🗆 🛛 Chicken pox		
		Sickle cell disease Seizures Last seizure:			——— 🗆 🗆 Hepatitis A		
		Sleep disorders (e.g., sleep a	apnea)	Use CPAP: Yes 🗆 No 🗆	—— 🗌 🗌 Hepatitis B		
		Abdominal/digestive problem					
		Surgery			□ □ Other (i.e., HIB)		
		Serious injury			Exemption to immunizations claimed		
		Other			(form required).		
his par	medica rt of the		l EpiPen info	ce is needed, please photocopy rmation must be included, even			
Medica	ation		Medicati	on	Medication		
Medication Strength			_	Frequency			
Approximate date started			-	nate date started			
Reason for medication			for medication				
Madia	ation		Medicati	on	Medication		
			on Frequency				
		-	nate date started				
Docos	Reason for medication		- Reason 1	for medication	Reason for medication		
Reasor							

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.

Part B INFORMED CONSENT AND HOLD HARMLESS/RELEASE AGREEMENT

High-adventure ba	se 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 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				
	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.

Part B Full name:	DOB:	680-001 2011 Printing
This Annual Health and Medical Record is valid fo	or 12 calendar months.	
Second parent/guardian signature	(if required; for example, CA)	
Second parent/quardian signature	Date	
Parent/guardian's signature	(if participant is under the age of 18)	
Participant's signature	Date	
Participant's name		

Rev. 2/2011

Part C

High-adventure base participants: Expedition/crew No.:

or staff position: _

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.

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.

	Explain Any Abnormalities	Range of Mobility	Normal	Abnormal	Explain Any Abnormalities
		Knees (both)			
		Ankles (both)			
		Spine			
		7			
		Other	Yes	No	
		Contacts			
		Dentures			
		Braces			
		Inguinal hernia			Explain
		Medical equipment (i.e., CPAP, oxygen)			
kin test (if	kin test (if required by you	kin test (if required by your state for BSA camp s	Spine Other Other Contacts Dentures Braces Inguinal hernia Medical equipment (i.e., CPAP, oxygen)	Spine Other Yes Contacts Dentures Braces Inguinal hernia Medical equipment (i.e., CPAP, oxygen)	Spine Other Yes No Other Yes Dentures Braces Inguinal hernia Medical equipment (i.e., CPAP, oxygen)

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)

Date ____

- □ □ 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

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

Dept. of Agriculture and the Dept. of Health & Human Services.

REVIEW FOR CAMP OR SPECIAL ACTIVITY Reviewed by	DO NOT WRITE IN THIS BOX
Further approval required ☐ Yes ☐ No Reason Bv	
,	

____ Date

Date

Part C Full name: _____

DOB: