# Treasure Valley Scout Reservation Medical Form

## For Boy Scout and Webelos Resident Camp

Mohegan Council, Boy Scouts of America

***Meets All BSA Health and Medical Record Class 3 Requirements***

This Health and Medical Record is required for participation in resident camp at Treasure Valley Scout Reservation. Each participant at Treasure Valley is subject to medical recheck. Treasure Valley recognizes the right to a Scout not to have immunizations etc. because of religious beliefs; however, a statement signed by the parents is required, indicating that the Scout is free from contagious disease and is able to physically tolerate camping at Treasure Valley. Write to Mohegan Council, 19 Harvard Street, Worcester, MA 01609 for a copy of the statement required.

**IMPORTANT** – The participant must provide a CURRENT health history, a CURRENT immunization record, and a report of a physical examination conducted during the preceding 24 months (CMR 430.151*). Adults 40 years of age or over must show evidence of physical exam within the past 12 months (BSA National Standards*). *details for standards and regulations available upon request.

**DIRECTIONS** –

1. Complete “Identifying Information”, “Emergency Information/Health History”, and “Medication” sections.
2. Physician’s Office verifies immunizations history and SIGNS WHERE INDICATED – OR – attached signed report of physical examination conducted during the preceding 24 months (for persons 40 years of age or over, within the preceding 12 months).
3. Health care provider completes physical examination and SIGNS WHERE INDICATED – OR- attached signed report of physical examination conducted during the preceding 12 months.
4. Participant (or parent / guardian of participant under 18 years of age) SIGNS in all areas indicated.
5. DO NOT mail this form anywhere!!! Bring it to camp and to the medical recheck.

**PER STATE AND BSA REGULATIONS:**

**FAILURE TO PROPERLY COMPLETE THIS FORM WILL RESULT IN THE INDIVIDUAL NOT BEING ADMITTED TO CAMP.**

**IDENTIFYING INFORMATION** – To be completed by Parent or Participants 18 years of age or older.

**NAME:** ______________________________ **DOB:** __________ **SEX:** ______ **AGE:** ______

ADDRESS: ______________________________ CITY: ____________ STATE: ____ ZIP: ______

**IN THE EVENT OF EMERGENCY, PLEASE NOTIFY** (give full names, area codes, and telephone numbers)

Mother: __________________ Home Tel: __________ Work Tel: __________ Mobile: __________

Father: __________________ Home Tel: __________ Work Tel: __________ Mobile: __________

Please notify both parents. In the event that neither parent can be reached, or for adult participant, call:

Name: __________________ Relationship: ______ Home Tel: __________ Work Tel: __________

Parents’ vacation address, if any: ______________________________ Telephone: ____________

Insurance Co. or HMO: ________________________ Policy #: ____________

Insurance Co. or HMO address: ____________________ City and State: ____________ Zip: _____

Please attach a photocopy of insurance card. If family has no insurance, state “NONE”.

Physician’s Name: __________________ City & State: ____________ Tel: ____________

# Treasure Valley Scout Reservation Medical Form (page 2)

## EMERGENCY INFORMATION / HEALTH HISTORY – To be completed by Parent or Participants 18 years of age or older.

**IS THE PARENT / PARTICIPANT AWARE OF ANY CURRENT HEALTH PROBLEMS?** _____No _____ Yes

Details: ______________________________________________

**IS THE PARTICIPANT UNDER MEDICAL CARE FOR ANY REASON?** _____No _____ Yes

Details: ______________________________________________

**HAS THERE BEEN ANY SURGERY, INJURY, ILLNESS, ALLERGY, OR CHANGE IN HEALTH STATUS SINCE LAST COMPLETE PHYSICAL EXAMINATION?** _____No _____ Yes Detail: ______________________

**IS THERE DISEASE OF, OR PAST OR PRESENT HISTORY OF:**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Serious illness | ___No | ___ Yes | Bridge | ___No | ___ Yes | Sugar | ___No | ___ Yes |
| Serious injury | ___No | ___ Yes | Chest, Lungs | ___No | ___ Yes | Infection | ___No | ___ Yes |
| Deformity | ___No | ___ Yes | Heart | ___No | ___ Yes | Bed wetting | ___No | ___ Yes |
| Surgery | ___No | ___ Yes | Murmur | ___No | ___ Yes | Menstrual | ___No | ___ Yes |
| Skin, Glands | ___No | ___ Yes | Rheumatic fever | ___No | ___ Yes | Hernia | ___No | ___ Yes |
| Ears, Eyes | ___No | ___ Yes | Stomach, Bowels | ___No | ___ Yes | Back, Limbs | ___No | ___ Yes |
| Nose, Sinus | ___No | ___ Yes | Appendicitis | ___No | ___ Yes | Sleepwalking | ___No | ___ Yes |
| Teeth, Tonsils | ___No | ___ Yes | Kidneys, Urine | ___No | ___ Yes | Nervousness | ___No | ___ Yes |
| Dentures | ___No | ___ Yes | Albumin | ___No | ___ Yes | Tuberculosis | ___No | ___ Yes |

Details: ______________________________________________

**PARTICIPANT HAS OR IS SUBJECT TO THE FOLLOWING** (give details for any checked):

_____ Allergy to a medicine, food, plant or insect toxin: ______________________

_____ Any condition that may require special care, medication, or diet: ______________________

_____ ADHD (Attention Deficit Hyperactivity Disorder)

| | | | |
|---|---|---|---|
| _____ Asthma | _____ Contact Lenses | _____ Dentures | _____ Fainting Spells |
| _____ Bleeding | _____ Convulsions | _____ Diabetes | _____ Heart Trouble |

Details: ______________________________________________

## MEDICATIONS – To be completed by Parent or Participants 18 years of age or older.

**IF PARTICIPANT IS UNDER 18 YEARS OF AGE:**
Is the participant bringing any medications (prescriptions or over the counter) to camp? ____ No ____ Yes.
If yes, please complete the Authorization to Administer Medication to a Camper or Staff Member under 18 years of age section on page 4 of this packet.

**IF PARTICIPANT IS 18 YEARS OF AGE OR OLDER:**
Is the participant bringing any medications to camp? _____ No _____ Yes
If yes, list medications: ______________________________________________

# Treasure Valley Scout Reservation Medical Form (page 3)

**IMMUNIZATIONS** – Per Massachusetts State regulations, Must be varified by Physician's Office.

Has the participant had chicken pox? ___ No ___ Yes

Has the participant had chicken pox vaccine? ___ No ___ Yes

**FOR CAMPERS AND STAFF UNDER 18 YEARS OLD** – (please indicate dates on lines below)

MMR Dose 1 ______ Dose 2 ______

Polio Dose 1 ______ Dose 2 ______ Dose 3 ______ Dose 4 ______

DTP Dose 1 ______ Dose 2 ______ Dose 3 ______ Dose 4 ______

Hepatitis B required for all children born on or after January 1, 1992. Dose 1 ______

**FOR CAMPERS AND STAFF 18 YEARS OLD AND OLDER** – (please indicate dates on lines below)

Measles: Born before 1957 ______, or Laboratory evidence of immunity ______, Dose 1 ______ Dose 2 ______

Mumps: Born before 1957 ______, or Laboratory evidence of immunity ______, Dose 1 ______

Rubella: Laboratory evidence of immunity ______, Dose 1 ______

Diphtheria and Tetanus Toxaids*: Polio Dose 1 ______ Dose 2 ______ Dose 3 ______

*A booster dose of tetanus, diphtheria, adult type toxaid (Td) is required if more than 10 years have passed since the last one.

**Physician's Office Verification: ______________________________ Date: __________**

**PHYSICAL EXAMINATION** – To be completed by LICENSED HEALTH CARE PROVIDER

Height ________ Weight ________ B.P. ______/_______ Pulse ___________

Vision: Normal _______ Glasses ________ Contacts __________

Hearing: Normal _______ Abnormal ______ Hearing Aide ______

**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: ________________________________________________

**APPROVED FOR PARTICIPATION IN:**

___ Hiking and camping _____ Water activities _____ Competitive sports _____ All activities

Specify exceptions: ________________________________________________

Recommendations (explain any restrictions OR limitations): ______________________________

**Physician's Verification: ______________________________ Date: __________**

**Health Care Practitioner Licensed to Perform Physical Examination's Information:**

**Telephone: ______________________ Address: ______________________________**

**AUTHORIZATION TO ADMINISTER MEDICATION TO A CAMPER OR STAFF UNDER 18 YEARS OF AGE** – To be completed by parent or legal guardian.

**NAME OF CAMPER/UNDERAGE STAFF**: ______________________________ Age: ________

Parent/Guardian Name: ______________________________

Home Phone: ______________ Business Phone: ______________ Mobile: ______________

Food/Drug Allergies: ______________________________

Diagnosis (at parents discretion): ______________________________

Name of Licensed Prescriber: ______________________________

Perscriber's Telephone: ______________

**NAME OF MEDICATION**: ______________________________

**DOSE GIVEN AT CAMP**: __________ **ROUTE OF ADMINISTRATION**: __________ **FREQUENCY**: __________

Date Ordered: ______________ Duration of Order: ______________ Quantity Received: __________

Expiration date of Medications Received: __________ Special Storage Requirements: ______________

**SPECIFIC DIRECTIONS** (e.g., on empty stomach/with water): ______________________________

Specific Precautions: ______________________________

Possible Side Effects/Adverse Reactions: ______________________________

**OTHER MEDICATIONS** (at parents' discretion): ______________________________

Location where medication administration will occur: ______________________________

**I hereby authorize Treasure Valley Scout Reservation to administer to my child, ______________ (Name of Child), the medication(s) listed above, in accordance with 105 CMR 430.160.**

105 CMR 430.160(A)
Medication prescribed for campers shall be kept in original containers bearing the pharmacy label, which shows the date of filling, the pharmacy name and address, the filling pharmacist's initials, the serial number of the prescription, the name of the patient, the name of the prescribing practitioner, the name of the prescribed medication, directions for use and cautionary statements, if any, contained in such prescription or required by law, and if tablets or capsules, the number in the container. All over the counter medications for campers shall be kept in the original containers containing the original label, which shall include the directions for use.
105 CMR 430.160(C)
Medication shall only be administered by the health supervisor* or by a licensed health care professional authorized to administer prescription medications. The health care consultant shall acknowledge in writing the list of medications administered at the camp. If the health supervisor is not a licensed health care professional authorized to administer prescription medications, the administration of medications shall be under the professional oversight of the health care consultant. Medication prescribed for campers brought from home shall only be administered if it is from the original container, and there is written permission from the parent/guardian.
105 CMR 430.160(D)
When no longer needed, medications shall be returned to a parent of guardian whenever possible. If the medication cannot be returned, it shall be destroyed.
*Health Supervisor – A person who is at least 18 years of age, specially trained and certified in at least current American Red Cross First Aid (or its equivalent) and CPR, has been trained in the administration of medications and is under the professional oversight of a licensed health care professional authorized to administer prescription medications.

**PARENT/GUARDIAN SIGNATURE:** ______________________________ **DATE:** ______________

# Treasure Valley Scout Reservation Medical Form (page 5)

**PARENTAL STATEMENT AND TALENT RELEASE** – Parent or Participant over 18 please read and sign.

I, the undersigned, have read and understood this entire form. The information provided herein is accurate and complete. The person described herein has permission for the full participation in the BSA programs, subject to any limitations noted herein. In the event of illness or accident in the course of such activity, I hereby request that measures be instituted without delay as the judgment of medical personnel dictates. These measures may include but are not limited to treatment in camp, transportation to and out–of camp medical facility, treatment at such facility, and any outside physician, hospital, or treatment facility to release and exchange any and all information connected with treatment.

I hereby assign and grant to the Boy Scouts of America the right and permission to use and publish any photographs/film/video tapes/electronic representations and/or sound recordings made of me (or my child) by the Boy Scouts of America, and I hereby release the Boy Scouts of America 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/video tapes/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 (or my child) may have for any of the foregoing.

*Note: Once submitted, this form becomes the property of Treasure Valley Scout Reservation. Parents, participants, and / or Troop Leaders who need extra copies are urged to make them prior to coming to camp.*

**Participant's Signature** (if 18 or older)**:** ______________________________ **Date:** __________

**Parent's Signature** (if participant is under 18)**:** ___________________________ **Date:** __________

*****TROOP LEADER AND CAMP SCREENING*****

Reviewed by Unit Leader (print) ____________________ Signature _____________________ Date ________

Screened at Camp by ____________________________ OK'd _______________________ Date ________

Notes: ________________________________________________________________________

Screened at Camp by ____________________________ OK'd _______________________ Date ________

Notes: ________________________________________________________________________

Additional Comments: ______________________________________________________________

__________________________________________________________________________________