BOY SCOUTS OF AMERICA®
NASHUA VALLEY COUNCIL

2019 Summer Camp Medical Form Instructions

BSA standards and state laws require accurate medical records for campers and staff. They are also critical to ensure timely, effective care should you or your Scout become sick or injured while at camp. All campers, adult leaders and staff MUST complete the BSA Annual Health and Medical Record form annually. Forms expire after the last day of the 12th calendar month from the physical exam date.

Without a completed medical form, Scouts, leaders, parents, and visitors WILL NOT PARTICIPATE in many camp activities including (but not limited to) swimming, boating, climbing, COPE, and sports, and may not remain in camp longer than 72 hours.

Read the medical form carefully. The next page highlights areas that are commonly incomplete. All portions of the form must be completed for ALL summer camp programs. Please take note of the following:

Part A

This page contains an important risk advisory, informed consent, and release. Please read this advisory carefully. The participant and parents (if participant is under 18) must sign to acknowledge agreement with the information on this page. This page also includes space to list adults who are authorized (or prohibited) to take this participant to/from events.

Part B

Part B contains the participant's contact and insurance information and general health history. Page 2 of this section contains information about medication and allergies. Please complete these sections carefully and accurately. The parents and health care professional must sign to authorize all medication **including non-prescription medication.**

Part C

Part C is the annual physical. This page should be completed and signed by the health care professional conducting the physical examination. Physicals are required for all events lasting longer than 72 hours. Physicals expire after the last day of the 12th calendar month from the physical exam date (similar to car inspection stickers)

Common Mistakes

- Missing parent/guardian signature (Part A)
- Missing emergency contact information (Part B)
- Incomplete medication information (Part B)
- Missing signature for non-prescription medication (Part B)
- Missing medical insurance card (Part B)
- Missing complete immunization record (Part B)
- Missing physician signature (Part B & C)
- Physical exam more than 12 months ago (Part C)

NOTE: State regulations require that a copy of your complete immunization record be attached to your medical form.

MEDICAL FORMS ARE NOT RETURNED AT THE END OF CAMP

Always submit a **COPY** of your medical form. Keep the original for use at other Scouting activities.

Part A – Page 1

Part A: Informed Consent, Release Agreement, and Authorization **A**

Full name: _____
DOB: _____

High-adventure base participants:
Expedition/crew No.: _____
or staff position: _____

Informed Consent, Release Agreement, and Authorization

With appreciation of the dangers and risks associated with programs and activities, on my own behalf and/or on behalf of my child, I hereby fully and completely release and waive any and all claims for personal injury, death, or loss that may arise against the Boy Scouts of America, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with any program or activity.

I also hereby assign and grant to the local council and the Boy Scouts of America, as well as their authorized representatives, 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 further 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 BSA, and I specifically waive any right to any compensation I may have for any of the foregoing.

NOTE: Due to the nature of programs and activities, the Boy Scouts of America and local councils cannot continually monitor compliance of program participants or any limitations imposed upon them by parents or medical providers. However, so that leaders can be as familiar as possible with any limitations, list any restrictions imposed on a child participant in connection with programs or activities below.

List participant restrictions, if any: ☐ None

Participant's signature: _____

Parent/guardian signature for youth: _____ (If participant is under the

Second parent/guardian signature for youth: _____ (If required; for example,

Complete this section for youth participants

Adults Authorized to Take to and From Events:

You must designate at least one adult. Please include a telephone number.
Name: _____ Telephone: _____
Name: _____ Telephone: _____

Adults NOT Authorized to Take Youth To and From Events:

Name: _____ Telephone: _____
Name: _____ Telephone: _____

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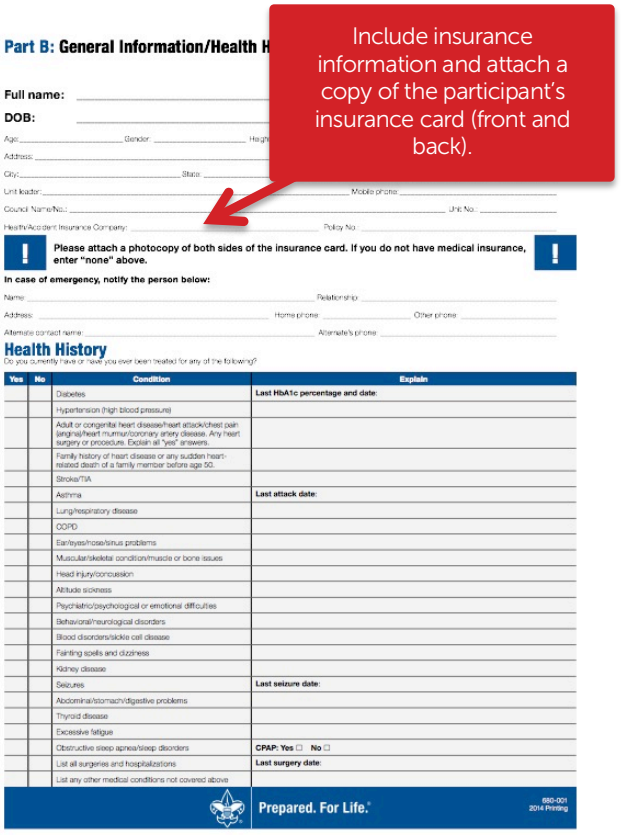
Participants and parents (if participant is under 18) must sign to acknowledge the informed consent and release on this page.

Adults authorized to, or prohibited from, taking a participant to/from and event.

Part B – Page 1



Part B: General Information/Health H

Full name: _____
DOB: _____

Age: _____ Gender: _____ Height

Address: _____

City: _____ State: _____

Unit leader: _____ Mobile phone: _____

Council Name/No.: _____ Unit No.: _____

Health/Accident Insurance Company: _____ Policy No.: _____

Please attach a photocopy of both sides of the insurance card. If you do not have medical insurance, enter "none" above.

In case of emergency, notify the person below:

Name: _____ Relationship: _____

Address: _____ Home phone: _____ Other phone: _____

Alternate contact name: _____ Alternate's phone: _____

Health History

Do you currently have or have you ever been treated for any of the following?

Yes	No	Condition	Explain
		Diabetes	Last HbA1c percentage and date:
		Hypertension (high blood pressure)	
		Adult or congenital heart disease/heart attack/chest pain (angina)/heart murmur/coronary artery disease. Any heart surgery or procedure. Explain all "yes" answers.	
		Family history of heart disease or any sudden heart-related death of a family member before age 50.	
		Stroke/TIA	
		Asthma	Last attack date:
		Lung/respiratory disease	
		COPD	
		Ear/eyes/nose/sinus problems	
		Muscular/skeletal condition/muscle or bone issues	
		Head injury/concussion	
		Altitude sickness	
		Psychiatric/psychological or emotional difficulties	
		Behavioral/neurological disorders	
		Blood disorders/sickle cell disease	
		Fainting spells and dizziness	
		Kidney disease	
		Seizures	Last seizure date:
		Abdominal/stomach/digestive problems	
		Thyroid disease	
		Excessive fatigue	
		Obstructive sleep apnea/sleep disorders	CPAP: Yes ☐ No ☐
		List all surgeries and hospitalizations	Last surgery date:
		List any other medical conditions not covered above	

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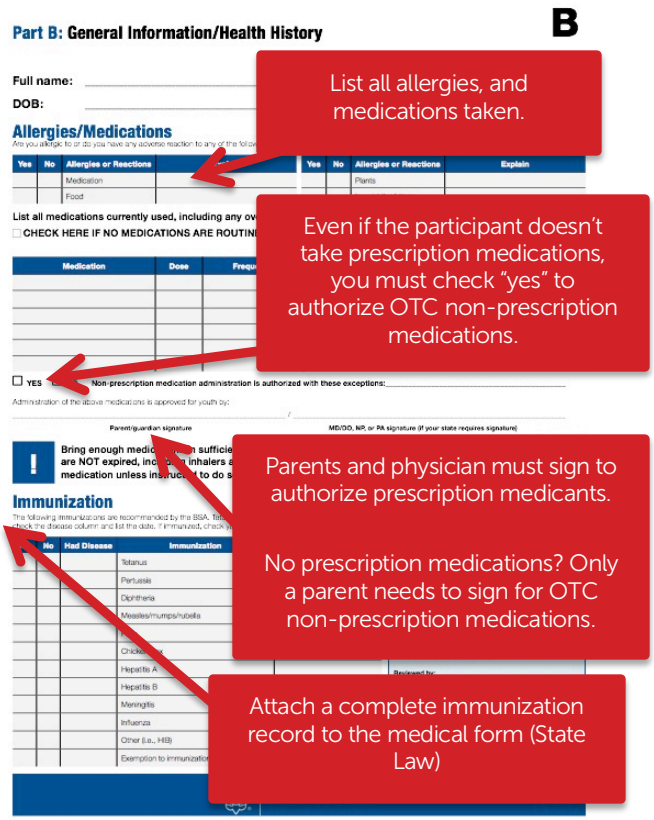
Include insurance information and attach a copy of the participant's insurance card (front and back).

Part B – Page 2



Part B: General Information/Health History **B**

Full name: _____
DOB: _____

Allergies/Medications

Yes	No	Allergies or Reactions	Yes	No	Allergies or Reactions	Explain
		Medication			Plants	
		Food				

List all medications currently used, including any ov
☐ CHECK HERE IF NO MEDICATIONS ARE ROUTIN

Medication	Dose	Frequ

☐ YES ☐ Non-prescription medication administration is authorized with these exceptions: _____

Administration of the above medications is approved for youth by:

_____ / _____
Parent/guardian signature MD/DO, NP, or PA signature (if your state requires signature)

Bring enough medic sufficie are NOT expired, inc inhalers a medication unless instruc to do s

Immunization

The following immunizations are recommended by the BSA. Ti Check the disease column and list the date. If immunized, check

No	Had Disease	Immunization
		Tetanus
		Pertussis
		Diphtheria
		Measles/mumps/rubella
		Chicken
		Hepatitis A
		Hepatitis B
		Meningitis
		Influenza
		Other (i.e., HIB)
		Exemption to immunizatio

List all allergies, and medications taken.

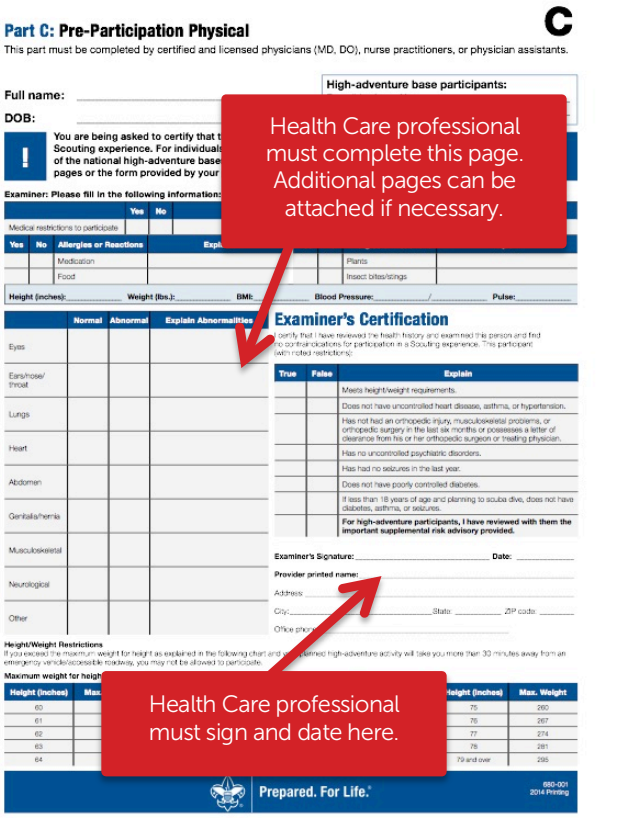
Even if the participant doesn't take prescription medications, you must check "yes" to authorize OTC non-prescription medications.

Parents and physician must sign to authorize prescription medicants.

No prescription medications? Only a parent needs to sign for OTC non-prescription medications.

Attach a complete immunization record to the medical form (State Law)

Part C – Page 1



Part C: Pre-Participation Physical **C**

This part must be completed by certified and licensed physicians (MD, DO), nurse practitioners, or physician assistants.

Full name: _____
DOB: _____

High-adventure base participants:

You are being asked to certify that t Scouting experience. For individuals of the national high-adventure base pages or the form provided by your

Examiner: Please fill in the following information:

	Yes	No
Medical restrictions to participate		

Yes	No	Allergies or Reactions	Explain		Allergies or Reactions	Explain
		Medication			Plants	
		Food			Insect bites/stings	

Height (inches): _____ Weight (lbs.): _____ BMI: _____ Blood Pressure: _____/_____ Pulse: _____

	Normal	Abnormal	Explain Abnormalities
Eyes			
Ears/nose/throat			
Lungs			
Heart			
Abdomen			
Genitalia/hernia			
Musculoskeletal			
Neurological			
Other			

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):

True	False	Explain
		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 his or her 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.
		For high-adventure participants, I have reviewed with them the important supplemental risk advisory provided.

Examiner's Signature: _____ Date: _____

Provider printed name: _____

Address: _____

City: _____ State: _____ ZIP code: _____

Office phone: _____

Height/Weight Restrictions

If you exceed the maximum weight for height as explained in the following chart and your planned high-adventure activity will take you more than 30 minutes away from an emergency vehicle/accessible roadway, you may not be allowed to participate.

Maximum weight for height

Height (inches)	Max.	Height (inches)	Max. Weight
60		75	260
61		76	267
62		77	274
63		78	281
64		79 and over	295

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Health Care professional must complete this page. Additional pages can be attached if necessary.

Health Care professional must sign and date here.

Part A: Informed Consent, Release Agreement, and Authorization

A

Full name: _____

DOB: _____

High-adventure base participants:
Expedition/crew No.: _____
or staff position: _____

Informed Consent, Release Agreement, and Authorization

I understand that participation in Scouting activities involves the risk of personal injury, including death, due to the physical, mental, and emotional challenges in the activities offered. Information about those activities may be obtained from the venue, activity coordinators, or your local council. I also understand that participation in these activities is entirely voluntary and requires participants to follow instructions and abide by all applicable rules and the standards of conduct.

In case of an emergency involving me or my child, I understand that efforts will be made to contact the individual listed as the emergency contact person by the medical provider and/or adult leader. 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 parents or guardian, and/or determination of the participant's ability to continue in the program activities.

(If applicable) I have carefully considered the risk involved and hereby give my informed consent for my child to participate in all activities offered in the program. I further authorize the sharing of the information on this form with any BSA volunteers or professionals who need to know of medical conditions that may require special consideration in conducting Scouting activities.

With appreciation of the dangers and risks associated with programs and activities, on my own behalf and/or on behalf of my child, I hereby fully and completely release and waive any and all claims for personal injury, death, or loss that may arise against the Boy Scouts of America, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with any program or activity.

I also hereby assign and grant to the local council and the Boy Scouts of America, as well as their authorized representatives, 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 further 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 BSA, and I specifically waive any right to any compensation I may have for any of the foregoing.

! **NOTE: Due to the nature of programs and activities, the Boy Scouts of America and local councils cannot continually monitor compliance of program participants or any limitations imposed upon them by parents or medical providers. However, so that leaders can be as familiar as possible with any limitations, list any restrictions imposed on a child participant in connection with programs or activities below.** !

List participant restrictions, if any: ☐ **None**

_____

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, Florida Sea Base, or the Summit Bechtel Reserve, I have also read and understand the supplemental risk advisories, 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. If the participant is under the age of 18, a parent or guardian's signature is required.

Participant's signature: _____ Date: _____

Parent/guardian signature for youth: _____ Date: _____

(If participant is under the age of 18)

Second parent/guardian signature for youth: _____ Date: _____

(If required; for example, California)

Complete this section for youth participants only:

Adults Authorized to Take to and From Events:

You must designate at least one adult. Please include a telephone number.

Name: _____

Telephone: _____

Name: _____

Telephone: _____

Adults NOT Authorized to Take Youth To and From Events:

Name: _____

Telephone: _____

Name: _____

Telephone: _____

Part B: General Information/Health History

B

Full name: _____

DOB: _____

High-adventure base participants:
Expedition/crew No.: _____
or staff position: _____

Age: _____ Gender: _____ Height (inches): _____ Weight (lbs.): _____

Address: _____

City: _____ State: _____ ZIP code: _____ Telephone: _____

Unit leader: _____ Mobile phone: _____

Council Name/No.: _____ Unit No.: _____

Health/Accident Insurance Company: _____ Policy No.: _____

! **Please attach a photocopy of both sides of the insurance card. If you do not have medical insurance, enter "none" above.** !

In case of emergency, notify the person below:

Name: _____ Relationship: _____

Address: _____ Home phone: _____ Other phone: _____

Alternate contact name: _____ Alternate's phone: _____

Health History

Do you currently have or have you ever been treated for any of the following?

Yes	No	Condition	Explain
☐	☐	Diabetes	**Last HbA1c percentage and date**:
☐	☐	Hypertension (high blood pressure)	
☐	☐	Adult or congenital heart disease/heart attack/chest pain (angina)/heart murmur/coronary artery disease. Any heart surgery or procedure. Explain all "yes" answers.	
☐	☐	Family history of heart disease or any sudden heart-related death of a family member before age 50.	
☐	☐	Stroke/TIA	
☐	☐	Asthma	**Last attack date**:
☐	☐	Lung/respiratory disease	
☐	☐	COPD	
☐	☐	Ear/eyes/nose/sinus problems	
☐	☐	Muscular/skeletal condition/muscle or bone issues	
☐	☐	Head injury/concussion	
☐	☐	Altitude sickness	
☐	☐	Psychiatric/psychological or emotional difficulties	
☐	☐	Behavioral/neurological disorders	
☐	☐	Blood disorders/sickle cell disease	
☐	☐	Fainting spells and dizziness	
☐	☐	Kidney disease	
☐	☐	Seizures	**Last seizure date**:
☐	☐	Abdominal/stomach/digestive problems	
☐	☐	Thyroid disease	
☐	☐	Excessive fatigue	
☐	☐	Obstructive sleep apnea/sleep disorders	**CPAP: Yes** ☐ **No** ☐
☐	☐	List all surgeries and hospitalizations	**Last surgery date**:
☐	☐	List any other medical conditions not covered above	

Part B: General Information/Health History

B

Full name: _____

DOB: _____

High-adventure base participants:
Expedition/crew No.: _____
or staff position: _____

Allergies/Medications

Are you allergic to or do you have any adverse reaction to any of the following?

Yes	No	Allergies or Reactions	Explain
☐	☐	Medication	
☐	☐	Food	
☐	☐	Plants	
☐	☐	Insect bites/stings	

List all medications currently used, including any over-the-counter medications.

☐ **CHECK HERE IF NO MEDICATIONS ARE ROUTINELY TAKEN.**

☐ **IF ADDITIONAL SPACE IS NEEDED, PLEASE INDICATE ON A SEPARATE SHEET AND ATTACH.**

Medication	Dose	Frequency	Reason

☐ **YES** ☐ **NO** **Non-prescription medication administration is authorized with these exceptions:** _____

Administration of the above medications is approved for youth by:

_____ / _____

Parent/guardian signature **MD/DO, NP, or PA signature (if your state requires signature)**

! **Bring enough medications in sufficient quantities and in the original containers. Make sure that they are NOT expired, including inhalers and EpiPens. You SHOULD NOT STOP taking any maintenance medication unless instructed to do so by your doctor.** **!**

Immunization

The following immunizations are recommended by the BSA. Tetanus immunization is required and must have been received within the last 10 years. If you had the disease, check the disease column and list the date. If immunized, check yes and provide the year received.

Yes	No	Had Disease	Immunization	Date(s)
☐	☐	☐	Tetanus	
☐	☐	☐	Pertussis	
☐	☐	☐	Diphtheria	
☐	☐	☐	Measles/mumps/rubella	
☐	☐	☐	Polio	
☐	☐	☐	Chicken Pox	
☐	☐	☐	Hepatitis A	
☐	☐	☐	Hepatitis B	
☐	☐	☐	Meningitis	
☐	☐	☐	Influenza	
☐	☐	☐	Other (i.e., HIB)	
☐	☐	☐	Exemption to immunizations (**form required**)	

Please list any additional information about your medical history:

DO NOT WRITE IN THIS BOX
Review for camp or special activity.

Reviewed by: _____

Date: _____

Further approval required: ☐ Yes ☐ No

Reason: _____

Approved by: _____

Date: _____

Part C: Pre-Participation Physical

C

This part must be completed by certified and licensed physicians (MD, DO), nurse practitioners, or physician assistants.

Full name: _____

DOB: _____

High-adventure base participants:
Expedition/crew No.: _____
or staff position: _____

! **You are being asked to certify that this individual has no contraindication for participation inside a Scouting experience. For individuals who will be attending a high-adventure program, including one of the national high-adventure bases, please refer to the supplemental information on the following pages or the form provided by your patient.** !

Examiner: Please fill in the following information:

	Yes	No	Explain
Medical restrictions to participate	☐	☐	

Yes	No	Allergies or Reactions	Explain	Yes	No	Allergies or Reactions	Explain
☐	☐	Medication		☐	☐	Plants	
☐	☐	Food		☐	☐	Insect bites/stings	

Height (inches):_____ **Weight (lbs.):**_____ **BMI:**_____ **Blood Pressure:**_____/_____ **Pulse:**_____

	Normal	Abnormal	Explain Abnormalities
Eyes	☐	☐	
Ears/nose/ throat	☐	☐	
Lungs	☐	☐	
Heart	☐	☐	
Abdomen	☐	☐	
Genitalia/hernia	☐	☐	
Musculoskeletal	☐	☐	
Neurological	☐	☐	
Other	☐	☐	

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):

True	False	Explain
☐	☐	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 his or her 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.
☐	☐	**For high-adventure participants, I have reviewed with them the important supplemental risk advisory provided.**

Examiner's Signature: _____ **Date:** _____

Provider printed name: _____

Address: _____

City: _____ State: _____ ZIP code: _____

Office phone: _____

Height/Weight Restrictions
If you exceed the maximum weight for height as explained in the following chart and your planned high-adventure activity will take you more than 30 minutes away from an emergency vehicle/accessible roadway, you may not be allowed to participate.

Maximum weight for height:

Height (inches)	Max. Weight	Height (inches)	Max. Weight	Height (inches)	Max. Weight	Height (inches)	Max. Weight
60	166	65	195	70	226	75	260
61	172	66	201	71	233	76	267
62	178	67	207	72	239	77	274
63	183	68	214	73	246	78	281
64	189	69	220	74	252	79 and over	295

BOY SCOUTS OF AMERICA®
NASHUA VALLEY COUNCIL

Permission to Possess & Use Epinephrine Auto-Injector and/or Asthma Inhaler

Pursuant to NH RSA 485-A:25-a-g, this form must be completed in its entirety and signed by a parent/guardian AND physician in order for your child to carry an auto-injector and/or asthma inhaler with him/her while at camp.

Physician's Section

Camper's Name:
Diagnosis requiring Epinephrine Auto-injector/Asthma Inhaler:
Are there any other medical conditions? ☐ Yes ☐ No If Yes, please explain:

Name/Dose/route of medication:	Date of Order:

Does the camper need assistance with administration of medication? ☐ Yes ☐ No If Yes, please explain:
Specific recommendations for administration (what symptoms would indicate need for administration of this medication?)
List any special side effects, contraindications and/or adverse reactions to be observed if the medication is administered:
List any adverse reactions that may occur to another child, for whom the above medication is not prescribed, should he or she receive a dose of the medication:

As the child's physician, I give permission for this child to possess and use Epinephrine auto-injector Asthma Inhaler. This child has the knowledge and skills to safely possess and use the identified medication in a camp setting	
Physician's Signature:	Date
Physician's Name (printed):	
Physician's Business Phone:	Emergency Phone:
Physician's Address:	

Parent/Guardian's Section

I hereby give permission for the camper named above to keep the above-named medication in his/her possession while attending a Nashua Valley Council Summer Camp. I will also provide a second auto-injector and/or asthma inhaler that, **by law**, must be kept at the health lodge for emergencies.

Parent/Guardian Signature:	Date: