2022 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. Please note 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)

Part D-NH

Part D-NH is unique to Camp Wanocksett. This page provides permission to possess & use epinephrine auto-injectors and/or asthma inhalers. The Scout's health care professional and the parent/guardian must sign the bottom of this page. This Is required by NH state regulations; this page is not required for Scouts attending any camps in Massachusetts.

Part D-MA

Part D-MA is unique to Treasure Valley and HNE's Cub Scout Day Camp Programs. This page includes authorizations for Scouts to participate in Shooting Sports activities during summer camp as well as be provided with specific over-the-counter medications. A parent/guardian must sign the bottom of this page. These items are required by MA state regulations; this page is not required for Scouts attending Camp Wanocksett.

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: NH State regulations require that a copy of your complete immunization record be attached to your medical form. MA State regulations require written documentation showing immunizations are up to date in accordance with the most current CDC Immunization Schedules.

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

Part A

Part A: Informed Consent, Release Agreement, and Authorization

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 B1

Part B1: General Information/Health History

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

Part B2

Part B2: General Information/Health History

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

Part C: Pre-Participation Physical

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: ______________________________

Date of birth: ______________________________

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.

Every person who furnishes any BB device to any minor, without the express or implied permission of the parent or legal guardian of the minor, is guilty of a misdemeanor. (California Penal Code Section 19915[a]) My signature below on this form indicates my permission.

I give permission for my child to use a BB device. (Note: Not all events will include BB devices.)

☐ **Checking this box indicates you DO NOT want your child to use a BB device.**

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 Scout Ranch, Philmont Training Center, Northern Tier, 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)

Complete this section for youth participants only:

Adults Authorized to Take Youth to and From Events:

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

Name: ______________________ Name: ______________________

Phone: ______________________ Phone: ______________________

Adults NOT Authorized to Take Youth to and From Events:

Name: ______________________ Name: ______________________

Phone: ______________________ Phone: ______________________

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Part B1: General Information/Health History

B1

Full name: ______________________________

Date of birth: ______________________________

High-adventure base participants:

Expedition/crew No.: ______________________

or staff position: ______________________

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

Address: ____

City: ____________________ State: ____________ ZIP code: ________ Phone: ____________

Unit leader: ______________________________ Unit leader's mobile #: ____________________

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:** **Insulin pump: Yes** ☐ **No** ☐
		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/reactive airway disease	**Last attack date:**
		Lung/respiratory disease	
		COPD	
		Ear/eyes/nose/sinus problems	
		Muscular/skeletal condition/muscle or bone issues	
		Head injury/concussion/TBI	
		Altitude sickness	
		Psychiatric/psychological or emotional difficulties	
		Neurological/behavioral disorders	
		Blood disorders/sickle cell disease	
		Fainting spells and dizziness	
		Kidney disease	
		Seizures or epilepsy	**Last seizure date:**
		Abdominal/stomach/digestive problems	
		Thyroid disease	
		Skin issues	
		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 B2: General Information/Health History

Full name: ______________________________

Date of birth: ______________________________

High-adventure base participants:

Expedition/crew No.: ______________________________

or staff position: ______________________________

Allergies/Medications

DO YOU USE AN EPINEPHRINE AUTOINJECTOR? Exp. date (if yes) ______________ ☐ YES ☐ NO

DO YOU USE AN ASTHMA RESCUE INHALER? Exp. date (if yes) ______________ ☐ YES ☐ NO

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

Yes	No	Allergies or Reactions	Explain	Yes	No	Allergies or Reactions	Explain
		Medication				Plants	
		Food				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 list 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. 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: ______________________________

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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: ____

Date of birth: ____

High-adventure base participants:

Expedition/crew No.: ____

or staff position: ____

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, 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. You can also visit www.scouting.org/health-and-safety/ahmr to view this information online.

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			
Skin issues			
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.
		Has no uncontrolled heart disease, lung disease, 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 planning to scuba dive, does not have diabetes, asthma, or seizures.

Examiner's signature: ______________________________ **Date:** ____________

Examiner's 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

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Part D-NH: 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 Heart of New England 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:

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Part D-MA: Supplement *Required for all youth participants at Treasure Valley and HNE's Cub Scout Day Camp Programs.*

Camper's Name: **DOB**:

Shooting Sports - Compliance to State Law : Authorized use of firearms by a minor

The Heart of New England Council adheres to all applicable laws and operates under the governance of BSA National Standards as well as MA State Health Code. As a part of the BSA program, the council operates several safe shooting sports ranges for Scouts to participate in BB shooting (Cub Scouts, BSA), rifle shooting & shotgun (Scouts, BSA & Venturing, BSA), and archery (All Programs). In order to meet the Mass General Laws Chapter 140 section 130 the Council requires parental permission to participate in such activities.

MA General Laws Chapter 140, Section 130 ½ "Lawfully furnishing weapons to minors for hunting, recreation, instruction and participation in shooting sports" stipulates the following:

> *"Notwithstanding section 130 or any general or special law to the contrary, it shall be lawful to furnish a weapon to a minor for hunting, recreation, instruction and participation in shooting sports while under the supervision of a holder of a valid firearm identification card or license to carry appropriate for the weapon in use; provided, however, that the parent or guardian of the minor granted consent for such activities."*

☐ **I hereby AUTHORIZE my child, named above, to participate in all events during summer camp including (if age appropriate) use of the shooting sports program areas (for rifle and shotgun under supervision of an FID instructor).**

☐ **I DO NOT AUTHORIZE my child, named above, to participate in shooting sports activities. However, my child is authorized to participate in all other events and activities of the camp.**

Over-the-Counter Medications

The following over-the-counter medications will be available through the health officer if a Scout becomes ill during camp. Please check the medications your child may be given if needed. Medicine will be administered per package instructions. Please send your child's own supply of over the counter medicine (in the original container) if they are a normal routine or taken daily.

NOTE: Failure to complete this section or to authorize any OTC Medication can result in an uncomfortable experience at camp. If you have any questions regarding administration of medications, please contact camp personnel.

Check all that are authorized:

☐ Acetaminophen (Tylenol)	☐ Pepto Bismol	☐ Bug Spray	☐ Sub Burn Cream (Aloe)
☐ Ibuprofen (Motrin)	☐ Decongestant	☐ After Bite	☐ Calamine Lotion
☐ Benadryl/Antihistamine	☐ Antacid	☐ Eye Drops	☐ Antibiotic Ointment
☐ Anti-Diarrhea	☐ Swimmer's Ear	☐ Sun Block	

Parent/Guardian's Signature: Date: