

2026 Summer Camp Medical Form Instructions

Scouting America 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 Scouting America Annual Health and Medical Record form annually. Forms expire after the last day of the 12th calendar month from the physical exam date (similar to car inspection stickers).

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. If your health care professional generates a form for their office that is used for sports, schools, or camp that includes an e-Signature, everything listed on Part C, and clears the participant to participate in activities without restrictions, attach it to the medical form - the physician does NOT have to sign part C in this case. Physicals are required for all events lasting longer than 72 hours.

Part D-NH (Only Applicable to Programs at Camp Wanocksett)

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 (Only Applicable to Programs at Treasure Valley)

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

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 regarding the risks of participation in Scouting activities is available to participants and their parents/guardians on the back of this form.

I, the undersigned, hereby authorize 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/videos/recordings/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 distribution of said photographs/videos/recordings/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) 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

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

I understand that the information here has been provided to be accurate. If my child or I do not wish to participate in any event or activity, I am participating at the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with any program or activity.

Participant's signature: _____ Date: _____
 Parent/guardian signature for youth: _____

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: _____ Phone: _____

Adults NOT Authorized to Take Youth to and From Events:
 Name: _____ Phone: _____

Adults authorized to, or prohibited from, taking a participant to/from an 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).

Full name: _____
 Date of birth: _____

Age: _____ Gender: _____ Height: _____
 City: _____ State: _____

Unit leader: _____
 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 phone: _____

Health History

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

Yes	No	Caution	Explain
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	Last HbA1c percentage and date: _____ Insulin pump: Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Hypertension (high blood pressure)	
<input type="checkbox"/>	<input type="checkbox"/>	Adult or congenital heart disease/heart attack/chest pain (angina)/heart murmur/coronary artery disease. Any heart surgery or procedure. Specify all "yes" answers.	
<input type="checkbox"/>	<input type="checkbox"/>	Family history of heart disease or any sudden heart-related death of a family member before age 50.	
<input type="checkbox"/>	<input type="checkbox"/>	Stroke/TIA	Last attack date: _____
<input type="checkbox"/>	<input type="checkbox"/>	Asthma/reactive airway disease	
<input type="checkbox"/>	<input type="checkbox"/>	Long/hospitalary disease	
<input type="checkbox"/>	<input type="checkbox"/>	COVID	
<input type="checkbox"/>	<input type="checkbox"/>	Ear/hears/neck/neck problems	
<input type="checkbox"/>	<input type="checkbox"/>	Muscular/skeletal condition/muscle or bone issues	
<input type="checkbox"/>	<input type="checkbox"/>	Head injury/concussion/TBI	
<input type="checkbox"/>	<input type="checkbox"/>	Altitude sickness	
<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric/psychological or emotional difficulties	
<input type="checkbox"/>	<input type="checkbox"/>	Neurological/behavioral disorders	
<input type="checkbox"/>	<input type="checkbox"/>	Blood disorders/sickle cell disease	
<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells and dizziness	
<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	
<input type="checkbox"/>	<input type="checkbox"/>	Seizures or epilepsy	Last seizure date: _____
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal/stomach/digestive problems	
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	
<input type="checkbox"/>	<input type="checkbox"/>	Skin issues	
<input type="checkbox"/>	<input type="checkbox"/>	Obstructive sleep apnea/sleep disorders	CPAP: Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	List all surgeries and hospitalizations	Last surgery date: _____
<input type="checkbox"/>	<input type="checkbox"/>	List any other medical conditions not covered above	

Part B2

Part B2: General Information/Health History

B2

Full name: _____
 Date of birth: _____

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

Allergies/Medications

DO YOU USE AN EPIPEN/EPINEPHRINE?
 AUTOMATICALLY: Exp. date (if any) _____

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

Yes	No	Allergies or Reactions	Explain
<input type="checkbox"/>	<input type="checkbox"/>	Medication	
<input type="checkbox"/>	<input type="checkbox"/>	Food	
<input type="checkbox"/>	<input type="checkbox"/>	Plants	

List all medications currently used, including any over-the-counter medications. Check here if no medications are routinely taken.

Medication	Dose	Frequency

Bring enough medications in sufficient quantities and in the original packaging to last the duration of the activity. If you have any maintenance medication and you are taking it, bring it with you.

Parent/guardian signature: _____ MEDICO, NR or PK signature (if your state requires signature)

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 medications.

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)

Immunization
 The following immunizations are recommended. Tetanus immunization is required every 10 years. If you had the disease, check the disease column and do not check the immunization column.

Yes	No	Risk Disease	Immunization
<input type="checkbox"/>	<input type="checkbox"/>	Tetanus	
<input type="checkbox"/>	<input type="checkbox"/>	Diphtheria	
<input type="checkbox"/>	<input type="checkbox"/>	Polio	
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A	
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B	
<input type="checkbox"/>	<input type="checkbox"/>	Meningitis	
<input type="checkbox"/>	<input type="checkbox"/>	Influenza	
<input type="checkbox"/>	<input type="checkbox"/>	Other (e.g., HB)	
<input type="checkbox"/>	<input type="checkbox"/>	Exemption to immunization	

Part C

Part C: Pre-Participation Physical

C

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 contraindications to participating in Scouting activities. If you are a health care professional, please refer to www.scouting.org/health-and-safety/leader to view this information.

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

Please fill in the following information:

Medical restrictions to participate	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Height (inches)	Weight (lbs.)	BMI	Blood Pressure	Pulse

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):

Yes	No	Explain
<input type="checkbox"/>	<input type="checkbox"/>	Meets height/weight requirements.
<input type="checkbox"/>	<input type="checkbox"/>	Has no uncontrolled heart disease, lung disease, or hypertension.
<input type="checkbox"/>	<input type="checkbox"/>	Has not had an orthopedic injury, musculoskeletal problem, or orthopedic surgery in the last six months or possesses a letter of clearance from his or her orthopedic surgeon or treating physician.
<input type="checkbox"/>	<input type="checkbox"/>	Has no uncontrolled psychiatric disorders.
<input type="checkbox"/>	<input type="checkbox"/>	Has had no seizures in the last year.
<input type="checkbox"/>	<input type="checkbox"/>	Does not have poorly controlled diabetes.
<input type="checkbox"/>	<input type="checkbox"/>	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.

Height (inches)	Max. Weight	Height (inches)	Max. Weight	Height (inches)	Max. Weight	Height (inches)	Max. Weight
40	75	48	100	56	125	64	150
41	76	49	101	57	126	65	151
42	77	50	102	58	127	66	152
43	78	51	103	59	128	67	153
44	79	52	104	60	129	68	154

Part A: Informed Consent, Release Agreement, and Authorization

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: _____



Part B1: General Information/Health History

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 <input type="checkbox"/> No <input type="checkbox"/>
		Hypertension (high blood pressure)	
		Adult or congenital heart disease/heart attack/chest pain (anginal)/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 <input type="checkbox"/> No <input type="checkbox"/>
		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: _____



Part C: Pre-Participation Physical

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
		Medication	
		Food	

Yes	No	Allergies or Reactions	Explain
		Plants	
		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



Prepared. For Life.®

Part D-NH: Permission to Possess & Use Epinephrine Auto-Injector and/or Asthma Inhaler

This form is only applicable to campers under the age of 18 attending Camp Wanocksett

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 them while at camp. MA School Forms do not meet NH Law and can not be accepted.

Physician's Section

Camper's Name:	
Diagnosis requiring Epinephrine Auto-injector/Asthma Inhaler:	
Are there any other medical conditions? <input type="radio"/> Yes <input type="radio"/> No If Yes, please explain:	
Name/Dose/route of medication:	
Date of Order:	
Does the camper need assistance with administration of medication? <input type="radio"/> Yes <input type="radio"/> 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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