

# HEART OF AMERICA COUNCIL PERSONAL HEALTH AND MEDICAL RECORD FORM - Class 3

**PLEASE TYPE OR PRINT** - Keep original for your record. Make reproductions for camp use. Be sure parents signature and date are original on reproduced copies.

**I. IDENTIFICATION** UNIT \_\_\_\_\_ DIST \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Date of Birth  
    
 Mo Day Year

Name \_\_\_\_\_  
 Last name First Name Initial

Address \_\_\_\_\_

City & State \_\_\_\_\_ Zip \_\_\_\_\_

Health/Accident Insurance \_\_\_\_\_ Policy # \_\_\_\_\_

**IN AN EMERGENCY NOTIFY:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

City & State \_\_\_\_\_ Bus. Phone \_\_\_\_\_

Personal Physician \_\_\_\_\_ Bus. Phone \_\_\_\_\_

## BOY SCOUTS OF AMERICA

All Class 3 activities require a health examination within the past 12 months by a licensed medical doctor or doctor of osteopathy. This includes youth and adult members participating in high-adventure activities, athletic competition, and world jamborees. Annually, this form is to be used by adults over 40 and for all activities requiring a physical examination and applies to *all* Wood Badge participants/staff and camp staff regardless of age.

### II. EMERGENCY MEDICAL INFORMATION

Has or is subject to (check and give details):

- Allergy to a medicine, food, plant, animal, or insect toxin.  Any condition that may require special care, medication, or diet.  Asthma  Convulsions  Heart trouble  
 Contact lenses  Diabetes  Fainting Spells  Bleeding disorders  Dentures

Please list medications and dosages on back.

EXPLAIN \_\_\_\_\_  
 \_\_\_\_\_

### III. AUTHORIZATION FOR TREATMENT

Has it ever been necessary to restrict applicant's activities for medical reasons?  No  Yes. Does applicant take medicine regularly or have special care?  No  Yes. If yes, explain:

To the best of my knowledge, the information in sections I, II, III, IV, and VI is accurate and complete. I request licensed Medical Doctor/Doctor of Osteopathy to examine applicant, to give needed immunization, and to furnish requested information to other agencies as needed. I give my permission for full participation in BSA programs, subject to limitations noted herein. In the event of illness or accident in the course of such activity. I request that measures be instituted without delay as judgment of medical personnel dictates.

Parent or guardian \_\_\_\_\_  
 (Must sign if applicant is 18 or younger)

Applicant's signature \_\_\_\_\_

Date Signed \_\_\_\_\_

### IV. IMMUNIZATIONS

If disease, put "D" and year.

	Last year given
Tetanus	_____
Diphtheria	_____
Pertussis	_____
Measles	_____
Mumps	_____
Rubella	_____
Polio	_____
Chicken Pox	_____

### V. LICENSED MEDICAL DOCTOR/DOCTOR OF OSTEOPATHY MEDICAL EVALUATION AND ADVICE

Approved for participation in:

- Hiking and camping  Water activities  
 Competitive Sports  All activities

Specify exceptions \_\_\_\_\_

Recommendations (explain any restrictions OR limitations):  
 \_\_\_\_\_

Date \_\_\_\_\_

Signed \_\_\_\_\_ M.D./D.O.

Signed \_\_\_\_\_ P.A./R.N.P.

if P.A., R.N.P. sign, the M.D./D.O. they are in collaborative practice with must sign above.

### VI. MEDICAL HISTORY

Parent (or applicant if 18 or older): Fill in sections I, II, III, IV, and VI before seeing licensed Medical Doctor/Doctor of Osteopathy. Check immunizations to be given at this time. Be sure to include any emergency information and restrictions or special care that should be observed. Especially be sure to record any injuries, illnesses, surgery, or significant changes in condition of health of applicant since last complete examination.

- Date of most recent complete physical examination (month & year) \_\_\_\_\_ 19\_\_\_\_\_
- Are you aware of any current health problems?  No  Yes
- Now under medical care or taking medicines?  No  Yes
- Has there been any surgery, injury, illness, allergy, or change in health status since last complete physical examination?  No  Yes

Give Dates and full details below for any "yes" answers.

IS THERE DISEASE OF (OR PAST OR PRESENT HISTORY OF):	No		Yes		Year	Details
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Serious Illness	<input type="checkbox"/>	<input type="checkbox"/>			_____	
Serious Injury	<input type="checkbox"/>	<input type="checkbox"/>			_____	
Deformity	<input type="checkbox"/>	<input type="checkbox"/>			_____	
Surgery	<input type="checkbox"/>	<input type="checkbox"/>			_____	
Skin, Glands	<input type="checkbox"/>	<input type="checkbox"/>			_____	
Ears, eyes	<input type="checkbox"/>	<input type="checkbox"/>			_____	
Teeth, tonsils	<input type="checkbox"/>	<input type="checkbox"/>			_____	
Dentures	<input type="checkbox"/>	<input type="checkbox"/>			_____	
Bridge	<input type="checkbox"/>	<input type="checkbox"/>			_____	
Chest, Lungs	<input type="checkbox"/>	<input type="checkbox"/>			_____	
Heart	<input type="checkbox"/>	<input type="checkbox"/>			_____	
Murmur	<input type="checkbox"/>	<input type="checkbox"/>			_____	
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>			_____	
Stomach, bowels	<input type="checkbox"/>	<input type="checkbox"/>			_____	
Appendicitis	<input type="checkbox"/>	<input type="checkbox"/>			_____	
Kidneys or urine	<input type="checkbox"/>	<input type="checkbox"/>			_____	
Albumin	<input type="checkbox"/>	<input type="checkbox"/>			_____	
Sugar	<input type="checkbox"/>	<input type="checkbox"/>			_____	
Infection	<input type="checkbox"/>	<input type="checkbox"/>			_____	
Bed-wetting	<input type="checkbox"/>	<input type="checkbox"/>			_____	
Menstrual problems	<input type="checkbox"/>	<input type="checkbox"/>			_____	
Hernia (rupture)	<input type="checkbox"/>	<input type="checkbox"/>			_____	
Back, limbs, joints	<input type="checkbox"/>	<input type="checkbox"/>			_____	
Sleepwalking	<input type="checkbox"/>	<input type="checkbox"/>			_____	
Nervous condition	<input type="checkbox"/>	<input type="checkbox"/>			_____	
Other (explain)	<input type="checkbox"/>	<input type="checkbox"/>			_____	

### VII. HEALTH EXAMINATION

#### Licensed Medical Doctor/Doctor of Osteopathy:

The applicant will be participating in a strenuous activity that will include one or more of the following conditions: athletic competition, adventure challenge or wilderness expedition (afloat or afoot) that may include high altitude, extreme weather conditions, cold water, exposure, fatigue, and/or remote conditions where readily available medical care cannot be assured.

- Please insist applicant furnish complete medical history (VI) before exam.
- Review immunizations; for youth (18 or younger) tetanus and diphtheria toxoid, measles, mumps, and rubella vaccines, and trivalent oral polio vaccine are required: youths and adults must have had tetanus booster within 10 years. A measles booster is recommended at age 12.
- After completing section VII, summarize any restrictions and/or recommendations in sections II and V, above, and sign.

VISION: \_\_\_\_\_ HEARING: \_\_\_\_\_  
 Date \_\_\_\_\_ Normal \_\_\_\_\_ Normal \_\_\_\_\_

Ht. \_\_\_\_\_ Wt. \_\_\_\_\_ Glasses \_\_\_\_\_ Abnormal \_\_\_\_\_

B.P. \_\_\_\_\_ / \_\_\_\_\_ Pulse \_\_\_\_\_ Contacts \_\_\_\_\_

Check box if normal; circle if abnormal and give details below:

- |   |   |
|---|---|
| <input type="checkbox"/> Growth, development    | <input type="checkbox"/> Teeth, tonsils     |
| <input type="checkbox"/> Genitourinary          | <input type="checkbox"/> Skin, glands, hair |
| <input type="checkbox"/> Respiratory            | <input type="checkbox"/> Skeletomuscular    |
| <input type="checkbox"/> Head, neck, thyroid    | <input type="checkbox"/> Cardiovascular     |
| <input type="checkbox"/> Neuropsychiatric       | <input type="checkbox"/> Eyes, ears, nose   |
| <input type="checkbox"/> Abdomen, hernia, rings | <input type="checkbox"/> Other (specify)    |

COMMENTS \_\_\_\_\_  
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LABORATORY: Urinalysis (Dip stick)  
 Albumin \_\_\_\_\_ Sugar \_\_\_\_\_

**MEDICATIONS, DOSAGE, AND INSTRUCTIONS:**

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