PERSONAL HEALTH AND MEDICAL RECORD: CLASS 1 AND CLASS 2

Class 1 (update annually for all participants). Activity: Day Camp, overnight hike, or other programs not exceeding 24 hours, with level of activity similar to that of home or school. Medical care is readily available. Current personal health and medical summary (history) is attested by parents to be accurate. This form is filled out by all participants and is on file for easy reference.

Class 2 (required once every 36 months for all participants under 40 years of age). Activities: Summer Camp, resident camp, and any other activity such as backpacking, tour camping, or recreational sports involving events with level of activity similar to that at home or school. Medical care is readily available. **All youth attending a Council Boy Scout summer camp, Cub/Webelos Rendezvous Camp must have a Class 2.**

If your child has had a medical evaluation (physical examination) within the last 36 months, a copy of the results of this examination must be attached to this health history for all participants in a camping experience lasting longer than 24 consecutive hours.

CLASS 1 PERSONAL HEALTH AND MEDICAL HISTORY

(annually by all participants)

To be filled out by parent, guardian, or adult participants. Please print in ink.

IDENTIFICATION

Name_____ Date of birth_____ Age_____ Sex_____

Name of parent or guardian_____ Telephone: H)_____ B)_____

Home address_____ City_____ State_____ Zip_____

Business address_____ City_____ State_____ Zip_____

If person named above is not available in the event of an emergency, notify:

Name_____ Relationship_____ Telephone_____
Name_____ Relationship_____ Telephone_____

Name of personal physician_____ Telephone_____

Personal health/accident insurance carrier_____ Policy No._____

Check all items that apply, past or present, to your health history. Explain any "Yes" answers.
ALLERGIES: Food, medicines, insects, plants Yes (__) No (__) Explain:_____

GENERAL INFORMATION:	YES	NO		YES	NO		YES	NO
Asthma	(__)	(__)	Diabetes	(__)	(__)	Kidney Disease	(__)	(__)
Cancer/leukemia	(__)	(__)	Heart trouble	(__)	(__)	Hemophilia	(__)	(__)
High blood pressure	(__)	(__)	Convulsions	(__)	(__)			

Explain:_____
List any medications to be taken at camp:_____
List any physical or behavioral conditions that may affect or limit full participation in swimming, backpacking, hiking long distances, or playing strenuous physical games:_____
List equipment needed such as wheelchair, braces, glasses, contact lenses, etc:_____

IMMUNIZATIONS:(give date of last inoculation)

Tetanus toxoid	_____	Measles	_____	Diphtheria	_____	Pertussis	_____
Mumps	_____	Rubella	_____	Polio	_____		

In case of emergency, I understand every effort will be made to contact me (if an adult, my spouse or next of kin).
In the event I cannot be reached, I hereby give my permission to the physician selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or infections of medication for my child (or for me, if an adult). The signature of the parent/guardian or adult is required on a yearly basis and indicates that all information is correct, up to date, and that a physical by a licensed physician occurred within the last 36 months.

Date_____ Signature of Parent/Guardian or adult_____ (Year 1)
Date_____ Signature of Parent/Guardian or adult_____ (Year 1)
Date_____ Signature of Parent/Guardian or adult_____ (Year 1)

CLASS 2 MEDICAL EVALUATION

(Required once every 36 months for all participants under 40 years of age. All youth attending a Council Boy Scout summer camp, Cub/Webelos Rendezvous Camp must have a Class 2).

Name_____ Age_____

NOTE TO LICENSED MEDICAL PRACTITIONERS*: The person being evaluated will be attending 1 or more weeks of camp that may include sleeping on the ground and participating in strenuous activities such as hiking, boating, and vigorous group games. Please review the HEALTH HISTORY with the participant for any interim changes. Explain any **"abnormal"** evaluations.

PHYSICAL EXAMINATION (To be filled out by a licensed medical practitioner)

Height_____ Weight_____ BP_____ / _____ Pulse_____

Lab: Urinalysis (dipstick)_____ Albumin_____ Sugar_____

VISION: Normal_____ Glasses_____ Contacts_____

HEARING: Normal_____ Abnormal_____ Explain_____

Check Box:	N	ABN		N	ABN
Growth development	(__)	(__)	Teeth	(__)	(__)
Skin	(__)	(__)	Cardiopulmonary system	(__)	(__)
Genitalia	(__)	(__)	Musculoskeletal	(__)	(__)
Hernia	(__)	(__)	Neurobehavioral	(__)	(__)
HEENT	(__)	(__)			

Explain:_____

LIMITATIONS:

Activity restrictions_____

Diet restrictions_____

Physician Signature_____ M.D./D.O./D.C./P.A./R.N.P.* Date_____

Address_____ Phone_____

City, State, ZIP_____

*Examinations conducted by doctors of chiropractic, physician's assistants, or pediatric nurse practitioners will be recognized only in states where they may perform physical examinations for students enrolled in public school systems.

INTERVAL RECORD	SCREENING EXAMINATION	
DATE, TIME, PLACE, ETC.	(Findings, diagnoses, treatment, instructions, disposition, etc.)	BY