# PERSONAL HEALTH AND MEDICAL RECORD FORM—Class 3

## I. IDENTIFICATION

Age _____ Sex _____ Date of Birth* (Mo. Day Year)

Name _____
Last Name First Name Initial

Address _____

City & State _____ Zip _____

Health/Accident Insurance_____ Policy No. _____

### IN AN EMERGENCY NOTIFY:

Name _____ Relationship _____

Address _____ Home Phone

City & State _____ Business Phone

Personal Physician _____ Phone

## III. PARENTAL STATEMENT

Has it ever been necessary to restrict applicant's activities for medical reasons? ☐ No ☐ Yes Does applicant take regular medicine 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 physician to examine appli- cant, to give needed immunization, and to furnish requested infor- mation 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 med- ical personnel dictates.

Parent or Guardian _____
(Must sign if applicant is under 18)

Applicant's Signature _____

Date signed _____

## IV. IMMUNIZATIONS:

| | Last Year Given |
|---|---|
| TETANUS | |
| DIPTHERIA | |
| POLIO | |
| | |

| Has had Disease | Vaccination |
|---|---|
| MEASLES | ☐ ☐ |
| MUMPS | ☐ ☐ |
| RUBELLA | ☐ ☐ |
| PERTUSSIS | ☐ ☐ |
| CHICKEN POX | ☐ |

Religious preference

## BOY SCOUTS OF AMERICA

All Class 3 activities require a health examination within the past 12 months by a physician.* This includes youth members participating in high-adventure activities, athletic competition, and national or world jamborees. This form is to be used by adults over 40 for all activities requiring a physical examination.

## 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

EXPLAIN _____

_____

## V. PHYSICIAN'S 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./D.C./P.A./R.N.P.*** (Circle one)
*Licensed medical practitioner

*In addition to examinations conducted by medical doctors and doctors of osteopathy, examinations will be recognized if conducted by doctors of chiropractic, physician's assistants, or pediatric nurse practitioners only in states where they may perform physical examinations on students enrolled in public school systems.

PLEASE TYPE OR PRINT

NAME _____ UNIT _____

NOTE: Keep original form for your personal record. Make reproductions for agency use. Be sure information and signatures are legible on reproduced copies. This upper section may be reproduced and carried with you for emergency identification and care.

## VI. MEDICAL HISTORY

**Parent (or applicant if over 18):** Fill in sections I, I, III, IV and VI *before seeing physician.* 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) _____
- 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 DESEASE OF (OR PAST OR PRESENT HISTORY OF): | No | Yes | Year | Details |
|---|---|---|---|---|
| Serious illness | ☐ | ☐ | _____ | |
| Serious injury | ☐ | ☐ | _____ | |
| Deformity | ☐ | ☐ | _____ | |
| Surgery | ☐ | ☐ | _____ | |
| Skin, glands | ☐ | ☐ | _____ | |
| Ears, eyes | ☐ | ☐ | _____ | |
| Nose, sinus | ☐ | ☐ | _____ | |
| Teeth, tonsils | ☐ | ☐ | _____ | |
| Dentures | ☐ | ☐ | _____ | |
| Bridge | ☐ | ☐ | _____ | |
| Chest, lungs | ☐ | ☐ | _____ | |
| Heart | ☐ | ☐ | _____ | |
| Murmur | ☐ | ☐ | _____ | |
| Rheumatic fever | ☐ | ☐ | _____ | |
| Stomach, bowels | ☐ | ☐ | _____ | |
| Appendicitis | ☐ | ☐ | _____ | |
| Kidneys or urine | ☐ | ☐ | _____ | |
| Albumin | ☐ | ☐ | _____ | |
| Sugar | ☐ | ☐ | _____ | |
| Infection | ☐ | ☐ | _____ | |
| Bed-wetting | ☐ | ☐ | _____ | |
| Menstrual problems | ☐ | ☐ | _____ | |
| Hernia (Rupture) | ☐ | ☐ | _____ | |
| Back, limbs, joints | ☐ | ☐ | _____ | |
| Sleepwalking | ☐ | ☐ | _____ | |
| Nervous condition | ☐ | ☐ | _____ | |
| Other (explain) | ☐ | ☐ | _____ | |

## VII. HEALTH EXAMINATION

**Physician:**

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 (afoot or afloat) 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 (under 18) tetanus and diphtheria toxoids, measles, mumps, and rubella vaccines, and trivalent oral polio vaccine are required; adults are required to have tetanus booster within 10 years.
- After completing section VII, summarize any restrictions and/or recommendations in sections II and V above, and sign.

DATE _____ VISION: Normal _____ HEARING: Normal _____

Ht. _____ Wt. _____ Glasses _____ Abnormal _____

B.P. _____ / _____ Pulse _____ Contacts _____

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

☐ Growth, development ☐ Teeth, tonsils ☐ Genitourinary
☐ Skin, glands, hair ☐ Respiratory ☐ Skeletomuscular
☐ Head, neck, thyroid ☐ Cardiovascular ☐ Neuropsychiatric
☐ Eyes, ears, nose ☐ Abdomen, hernia, rings ☐ Other (specify)

**COMMENTS** _____

_____

_____

_____

_____

_____

LABORATORY: Urinalysis (Dip stick) Albumin _____ Sugar _____

**FOR THOSE ATTENDING PHILMONT OR NATIONAL HIGH-ADVENTURE BASES:**

* The minimum age for all participants is 13 by January 1 of the year of participation. No exceptions.

† Trail food is by necessity a high carbohydrate, high caloric diet. It is high in wheat, milk products, sugar, corn syrup, and artificial coloring/flavoring. Dinner meals contain meat. If these food products cause a problem in your diet, you need to bring appropriate substitutions with you and so advise base personnel.

**Note:** Physicians representing high-adventure bases reserve the right to deny access to the trails or other program activity on the basis of a medical evaluation performed at the base after arrival.

No. 34412

1992 Printing created for web distribution

**REVIEW FOR CAMP OR SPECIAL ACTIVITY:**

| DATE | AGENCY AND ACTIVITY | BY | "OK" | PHYSICIAN RECHECK NEEDED | RESULTS OF RECHECK | INITIAL |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |

**INTERVAL RECORD** (CAMP, JAMBOREE, TOURNAMENT, TRAVEL, ETC.)

| DATE, TIME, PLACE, ETC. | FINDINGS, DIAGNOSES, TREATMENT, INSTRUCTIONS, DISPOSITION, ETC. | BY |
|---|---|---|
| | | |