Monmouth Council | Boy Scouts of America

Revised 8/2007

PLEASE TYPE OR PRINT

# PERSONAL HEALTH AND MEDICAL RECORD FORM

## I. IDENTIFICATION

Age____ Sex____ Date of Birth* [ ][ ][ ][ ][ ][ ] Mo. Day Year

Name________________________________________

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 [ ][ ][ ]

## SPECIAL DIETARY NEEDS

________________________________________

________________________________________

________________________________________

## 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
- ☐ ADHD (Attention Deficit Hyperactive Disorder)
- ☐ Asthma ☐ Convulsions ☐ Heart trouble ☐ Contact lenses
- ☐ Diabetes† ☐ Fainting spells ☐ Bleeding disorders ☐ Dentures

EXPLAIN________________________________________

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.

## III. PARENTAL STATEMENT

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 a licensed health-care practitioner 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. I give permission to administer any over the counter medications listed by the physician in section VIII. 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 Date mm/dd/yy |
|---|---|
| Tetanus | |
| Diphtheria | |
| Pertussis | |
| Measles | |
| Mumps | |
| Rubella | |
| Polio | |
| Hepatitis B | |
| HIB | |
| Chicken Pox | |

Religious preference

## V. LICENSED PHYSICIAN'S EVALUATION AND ADVICE (Licensed Physician)

Approved for participation in:

- ☐ Hiking and camping ☐ Water activities
- ☐ Competitive sports ☐ All activities

Specify exceptions______________________________

Recommendations (explain any restrictions OR limitations):______________________________

________________________________________

________________________________________

Date______________

Signed______________________________ *Licensed physician

Physician's signature indicates that the individual identified in section I has been examined and sections V, VII and VIII have been completed by the physician. The physician has also reviewed sections II, IV and VI.

## VI. MEDICAL HISTORY

**Parent (or applicant if 18 or older):** Fill in sections I, II, III, IV, and VI *before seeing a licensed health-care practitioner.* 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 and year)______________ 20____
- 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/Medicines |
|---|---|---|---|---|
| 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) | ☐ | ☐ | ______ | |

Please list ALL medications taken in the 30 days **prior** to arrival at the Scouting activity where this form is to be used:

______________________________

______________________________

______________________________

## VII. HEALTH EXAMINATION (Licensed 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 (18 or younger) tetanus and diphtheria toxoids, 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, complete section VIII belowand sign in section V above..

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________________________________________

________________________________________

________________________________________

________________________________________

________________________________________

________________________________________

## VIII. OVER THE COUNTER MEDICATIONS (Licensed Physician)

**Check box for each over the counter medication permitted**

- ☐ Tylenol, Adult ☐ Robitussin, Pediatric ☐ Mylanta
- ☐ Tylenol, Child ☐ Robitussin, DM ☐ Tums
- ☐ Tylenol, Chewable ☐ Robitussin, Cough Drop ☐ Chlortrimeton
- ☐ Tylenol, Elixir ☐ Sudafed ☐ Benadryl. Elixir
- ☐ Chloraseptic Spray ☐ Dimetapp ☐ Benadryl, Tablet

Other________________________________________ Provided by camper

Examining Physician's Name (PRINT)______________________________ Telephone______________________________

State Licensed in__________ Lic#______________________ Address______________________________

| REVIEW FOR CAMP OR SPECIAL ACTIVITY | | | | | | |
|---|---|---|---|---|---|---|
| DATE | AGENCY AND ACTIVITY | BY | "OK" | PHYSICIAN RECHECK NEEDED | RESULTS OF RECHECK | INITIAL |
| | | | | | | |
| | | | | | | |

| INTERVAL RECORD | (CAMP, CAMPOREE, TOURNAMENT, TRAVEL, ETC.) | |
|---|---|---|
| DATE, TIME, PLACE, ETC. | FINDINGS, DIAGNOSES, TREATMENT, INSTRUCTIONS, DISPOSITION, ETC. | BY: |
| | | |

## *MUST BE COMPLETED*

In the event my son must leave camp before scheduled,
I authorize the following persons to pick him up:

**Name(s)** **Telephone(s)**

_______________________________ _______________

_______________________________ _______________

_______________________________ _______________

Agency Other Than Original: Please accept Personal Health and Medical Record as evidence either of examination or that appropriate health review and memorandum was made by physician as of date signed. Other details are available from original agency or physician. Please return record to applicant after short-term activity. Copy may be made for applicants file, if needed.