

**PERSONAL HEALTH AND MEDICAL RECORD FORM—Class 3**

**I. IDENTIFICATION**

Age \_\_\_\_\_ Sex \_\_\_\_\_

Date of Birth\*

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

Mo.	Day	Year

Address \_\_\_\_\_

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

Health/Accident insurance \_\_\_\_\_ Policy no. \_\_\_\_\_

**IN AN EMERGENCY NOTIFY:**

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

Address \_\_\_\_\_ Home phone \_\_\_\_\_

City & State \_\_\_\_\_ Business phone \_\_\_\_\_

Personal phone \_\_\_\_\_

Physician Phone \_\_\_\_\_



**BOY SCOUTS OF AMERICA**

All Class 3 activities require a health examination within the past 12 months by a licensed health-care practitioner.\* 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 40 years of age or older for all activities requiring a physical examination and applies to *all* Wood Badge participants/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
- ADHD (Attention Deficit Hyperactive Disorder)
- Asthma       Convulsions       Heart trouble       Contact lenses
- Diabetes†       Fainting spells       Bleeding disorders       Dentures



EXPLAIN \_\_\_\_\_

**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.

**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. 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 \_\_\_\_\_

Updated \_\_\_\_\_ Signed \_\_\_\_\_ Parent or guardian

Updated \_\_\_\_\_ Signed \_\_\_\_\_ Parent or guardian

**IV. IMMUNIZATIONS**

If disease, put "D" and year.

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

Religious preference \_\_\_\_\_

**V. LICENSED HEALTH-CARE PRACTITIONER'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): \_\_\_\_\_

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

\*Licensed health-care practitioner

\*Examinations conducted by licensed health-care practitioners other than physicians will be recognized for BSA purposes in those states where such practitioners may perform physical examinations within their legally prescribed scope of practice.

**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	<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"/>	_____	
Nose, sinus	<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"/>	_____	_____

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 Health-Care Practitioner:

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 aloft) 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, 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:

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

COMMENTS \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**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, or have completed the seventh grade. No exceptions.
- † Trail food is by necessity a high-carbohydrate, high-calorie 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: Licensed health-care practitioners 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.