

TROOP 215 PERSONAL HEALTH AND MEDICAL RECORD FORM—Class 3

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.

I. IDENTIFICATION

Name _____ DOB _____ Age _____ Sex _____

Name of Parent or Gardian: _____

Address _____ City _____ ST _____ Zip _____

Phone: _____ Work: _____ Cell: _____

IN AN EMERGENCY NOTIFY:

Name: _____ Relationship _____ Phone: _____

Name: _____ Relationship _____ Phone: _____

Name: _____ Relationship _____ Phone: _____

Health/Accident Insurance _____ Policy no. _____

Personal Physician: _____ Phone: _____

Religious preference: _____

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 _____

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 _____ Dated _____
Applicant's signature _____ Dated _____

IV. LICENSED HEALTH-CARE PRACTITIONER'S EVALUATION AND ADVICE

Approved for participation in:
 All activities Hiking and camping Water activities Competitive sports

Specify exceptions _____

Recommendations (explain any restrictions OR limitations): _____

Signed _____ Date _____

* 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.

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

V. IMMUNIZATIONS If disease, put "D" and year.

Tetanus _____ Diphtheria _____ Pertussis _____ Measles _____
 Mumps _____ Rubella _____ Polio _____ Chicken Pox _____

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		NO	YES	YEAR/DETAILS
Serious illness	£	£	_____	Stomach, bowels	£	£	_____
Serious injury	£	£	_____	Appendicitis	£	£	_____
Deformity	£	£	_____	Kidneys or urine	£	£	_____
Surgery	£	£	_____	Albumin	£	£	_____
Skin, glands	£	£	_____	Sugar	£	£	_____
Ears, eyes	£	£	_____	Infection	£	£	_____
Nose, sinus	£	£	_____	Bed-wetting	£	£	_____
Teeth, tonsils	£	£	_____	Menstrual	£	£	_____
Dentures	£	£	_____	problems	£	£	_____
Bridge	£	£	_____	Hernia (rupture)	£	£	_____
Chest, lungs	£	£	_____	Back, limbs, joints	£	£	_____
Heart	£	£	_____	Sleepwalking	£	£	_____
Murmur	£	£	_____	Nervous condition	£	£	_____
Rheumatic fever	£	£	_____	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 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 (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, and sign.

Date _____ VISION: Normal/Glasses/Contacts _____ HEARING: Normal/Abnormal _____

Ht. _____ Wt. _____ B.P. _____ / _____ Pulse _____

Check box if normal. Circle if abnormal and give details below:

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

COMMENTS _____

