



Annual Health History Record

(Valid for 12 calendar months)

Medical Information

The Boy Scouts of America requests as of January 1, 2010 that all youth and adult members have annual medical evaluations by a certified and licensed health-care provider. In an effort to provide better care to those who may become ill or injured and to provide youth members and adult leaders a better understanding of their own physical capabilities, the Boy Scouts of America has established minimum standards for providing medical information prior to participating in various activities. Those standards are offered below in one three-part medical form. Note that unit leaders must always protect the privacy of unit participants by protecting their medical information.

Parts A and B are to be completed annually by ALL BSA unit members. Both parts are required for all events that do not exceed 72 consecutive hours, where the level of activity is similar to that normally expended at home or at school, such as day camp, day hikes, swimming parties or an overnight camp and where medical care is readily available. Medical information required includes a current health history and list of medications. Part A includes the parental informed consent and hold harmless/release agreement, a talent release statement, Lyme disease statement and permission to participate in shooting sports release. Adult unit leaders should review participants' health histories and become knowledgeable about the medical needs of the youth members in their unit. This form is to be filled out by participants and parents or guardians and kept on file for easy reference. All units should keep their own copy of their forms for any future camp visits; our camps are required to keep a copy of all completed forms that are turned in.

Risk Factors

Based on the vast experience of the medical community, the BSA has identified that the following risk factors may define your participation in various outdoor adventures.

- Excessive body weight
- Heart disease
- Hypertension (high blood pressure)
- Diabetes
- Seizures
- Lack of appropriate immunizations
- Asthma
- Sleep disorders
- Allergies/anaphylaxis
- Muscular/skeletal injuries
- Psychiatric/psychological and emotional difficulties.

For more information on medical risk factors, visit Scouting Safely on www.scouting.org.

Prescriptions

The taking of prescription medication is the responsibility of the individual taking the medication and/or that individual's parent or guardian. A leader, after obtaining all necessary information, can agree to accept the responsibility of making sure a youth takes the necessary medication at the appropriate time, but BSA does not mandate or necessarily encourage the leader to do so. Also, if state laws are more limiting, they must be followed.

This health form will need to be collected from everyone who attends one of our camps upon check in (youth and adult). Part A (statement/release) will be kept at camp, therefore, please make a copy of your forms to keep for your next camp visit throughout the coming year.



BOY SCOUTS OF AMERICA

Part A

RELEASE/STATEMENTS – each section requires an adult’s signature

Lyme disease – Be wary, not worried, when enjoying the outdoors!

Lyme disease is becoming increasingly common in Minnesota, Wisconsin and other states. Lyme disease is spread by the bite of certain ticks. It is important for people who work or recreate outdoors to learn the facts about the disease and to prevent it. By taking some simple precautions and knowing the symptoms of the disease, we can continue to safely enjoy the pleasures and benefits of the outdoors. The links below will help Scouters stay safe while enjoying the woods. www.stopticks.org; www.lymediseaseassociation.com; and www.ilads.org I have read and understand this.

Signature of Parent or Legal Guardian: _____ Date: _____

Informed Consent and Hold Harmless/Release Agreement

I understand that participation in Scouting activities involved a certain degree of risk. I have carefully considered the risk involved and have given consent for myself and/or my child to participate in these activities. I understand that participation in these activities is entirely voluntary and requires participants to abide by applicable rules and standards of conduct. I release the Boy Scouts of America, the local council, the activity coordinators and all employees, volunteers, related parties or other organizations associated with the activity from any and all claims or liability arising out of this participation.

I approve the sharing of the information on this form with BSA volunteers and professionals who need to know of medical situations that might require special consideration for the safe conducting of Scouting activities.

In case of an emergency involving me or my child, I understand that every effort will be made to contact the individual listed as the emergency contact person. In the event that this person cannot be reached, permission is hereby given to the medical provider selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery or injections of medication for me or my child. Medical providers are authorized to disclose to the adult in charge examination findings, test results, and treatment provide for purposes of medical evaluation of the participant, follow-up and communication with the participant’s parents or guardian, and/or determination of the participant’s ability to continue in the program activities.

- Without restrictions**
- With special considerations or restrictions (list)** _____

Signature of Parent or Legal Guardian: _____ Date: _____

Permission to Participate in Shooting Sports for all Cub Scouts, Boy Scouts, Venturers and Explorers:

I, _____ (print your name) grant my consent to Northern Star Council and to its representatives including Range Officers and Instructors and others serving in these positions to furnish my child with BB guns or firearms and ammunition and provide instruction as to their use. I further certify that I am the parent with full parental rights or the legal guardian of this child. I understand that this document will be kept and maintained by the Northern Star Council or its representatives including Range Officers and Instructors. I further understand that any modification of this form will result in it s not being accepted by Northern Star Council, Range Officers and Instructors.

- Yes my child has permission to participate in Shooting Sports without restrictions.**
- No, my child does not have permission to participate in any Shooting Sports.**

Signature of Parent or Legal Guardian: _____ Date: _____

I have read and understand all the information shared in this form. If any information I/we have provided is found to be inaccurate, it may limit and/or eliminate the opportunity for participation in any event or activity.

Participant’s name _____ Participant’s signature _____

Signature of Parent or Legal Guardian: _____ Date: _____
(if under the age of 18)

Participant’s Last Name: _____ **First Name:** _____ **DOB:** _____ **Unit #:** _____

This page needs to be completed by ALL for each camp you attend. Please retain a copy for your records.

Part B
HEALTH HISTORY

Name _____ Date of Birth _____ Age _____ Male Female
 Address _____ Grade completed (youth only) _____
 City _____ State _____ Zip _____ Phone No. _____
 Unit leader _____ Council Name/No. _____ **Unit No.** _____
 Social Security No. (optional; may be required by medical facilities for treatment) _____ Religious preference _____
 Health/accident insurance company _____ Policy No. _____

IF FAMILY HAS NO MEDICAL INSURANCE, STATE "NONE."

In case of emergency, notify:

Name _____ Relationship _____
 Address _____ Home _____
 Phone _____ Business phone _____ Cell phone _____
 Alternate Contact _____ Alternate's phone _____

MEDICAL HISTORY

Are you now, or have you been treated for any of the following:

Yes	No	Condition	Explain
		Asthma	
		Diabetes	
		Hypertension (high blood pressure)	
		Heart disease (i.e., CHF, CAD, MI)	
		Stroke/TIA	
		COPD	
		Ear/sinus problems	
		Muscular/skeletal condition	
		Menstrual problems (women only)	
		Psychiatric/psychological and emotional difficulties	
		Learning disorders (i.e., ADHD, ADD)	
		Bleeding disorders	
		Fainting spells	
		Thyroid disease	
		Kidney disease	
		Sickle cell disease	
		Seizures	
		Sleep disorders (i.e., sleep apnea)	
		GI problems (i.e., abdominal, digestive)	
		Surgery	
		Serious injury	
		Other	

Allergies or Reaction to:

Medication _____
 Food, Plants, or insect bites _____

Immunizations:

The following are recommended by the BSA. Tetanus immunization must have been received within the last 10 years. If had disease, put "D" and the year. If immunized, check the box and the year received.

- | Yes | NO | Date |
|--------------------------|--------------------------|-------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Tetanus _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Pertussis _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Diphtheria _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Measles _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Mumps _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Rubella _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Polio _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Chickenpox _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis A _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis B _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Influenza _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Other (i.e., HIB) _____ |
- Exemption to immunizations claimed.

MEDICATIONS

List all medications currently used. (IF additional space is needed, please photocopy this part of the health form.) Inhalers and EpiPen information must be included, even if they are for occasional or emergency use only.

(For more information about immunizations, as well as Immunization exemption form, see Scouting Safely on www.scouting.org.)

Medication _____ Strength _____ Frequency _____ Approximate date started _____ Reason for medication _____ _____ Distribution approved by: _____ Parent Signature _____ MD/DO, NP or PA Signature _____ Temporary <input type="checkbox"/> Permanent <input type="checkbox"/>	Medication _____ Strength _____ Frequency _____ Approximate date started _____ Reason for medication _____ _____ Distribution approved by: _____ Parent Signature _____ MD/DO, NP or PA Signature _____ Temporary <input type="checkbox"/> Permanent <input type="checkbox"/>	Medication _____ Strength _____ Frequency _____ Approximate date started _____ Reason for medication _____ _____ Distribution approved by: _____ Parent Signature _____ MD/DO, NP or PA Signature _____ Temporary <input type="checkbox"/> Permanent <input type="checkbox"/>
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NOTE: Be sure to bring medications in the appropriate containers, and make sure that they are NOT expired, including inhalers and EpiPens. You SHOULD NOT STOP taking any maintenance medication.

Unit # _____ Allergies: _____ DOB: _____ Last name: _____