Annual Health and Medical Record

(Valid for 12 calendar months)

Policy on Use of the Annual Health and Medical Record

In order to provide better care for its members and to assist them in better understanding their own physical capabilities, the Boy Scouts of America recommends that everyone who participates in a Scouting event have an annual medical evaluation by a certified and licensed health-care provider—a physician (MD or DO), nurse practitioner, or physician assistant. Providing your medical information on this four-part form will help ensure you meet the minimum standards for participation in various activities. 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 at least annually by participants in all Scouting events. This health history, parental/guardian informed consent and hold harmless/release agreement, and talent release statement is to be completed by the participant and parents/guardians.

Part C is the physical exam that is required for participants in any event that exceeds 72 consecutive hours, for all high-adventure base participants, or when the nature of the activity is strenuous and demanding. Service projects or work weekends may fit this description. Part C is to be completed and signed by a certified and licensed heath-care provider—physician (MD or DO), nurse practitioner, or physician assistant. It is important to note that the height/weight limits must be strictly adhered to when the event will take the unit more than 30 minutes away from an emergency vehicle–accessible roadway, or when the program requires it, such as backpacking trips, high-adventure activities, and conservation projects in remote areas. See the FAQs for when this does not apply.

Part D is required to be reviewed by all participants of a high-adventure program at one of the national high-adventure bases and shared with the examining health-care provider before completing Part C.

- Philmont Scout Ranch. Participants and guests for Philmont activities that are conducted with limited
 access to the backcountry, including most Philmont Training Center conferences and family programs,
 will not require completion of Part C. However, participants should review Part D to understand potential
 risks inherent at 6,700 feet in elevation in a dry Southwest environment. Please review specific registration
 information for the activity or event.
- Northern Tier National High Adventure Base.
- Florida National High Adventure Sea Base. The PADI medical form is also required if scuba diving
 at this base.

Risk Factors

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

- Excessive body weight
- Heart disease
- Hypertension (high blood pressure)
- Diabetes

- Seizures
- Lack of appropriate immunizations
- Asthma
- 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 the 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.

Frequently Asked Questions (FAQs)

- Philmont Scout Ranch: www.philmontscoutranch.org or 575-376-2281
- Northern Tier National High Adventure Base: www.ntier.org or 218-365-4811
- Florida National High Adventure Sea Base: www.bsaseabase.org or 305-664-5612
- National Scout Jamboree: www.bsajamboree.org

For frequently asked questions about this Annual Health and Medical Record, see Scouting Safely online at http://www.scouting.org/scoutsource/HealthandSafety.aspx. Information about the Health Insurance Portability and Accountability Act (HIPAA) may be found at http://www.hipaa.org.



Part A	1	A Health and Medical I	Record	High-adventure base participants: Expedition/crew No.: or staff position:				
GENERAL INFORMATION Name						Age Male ☐ Female ☐		
Unit leader Cou			reatment)					
		t insurance company						
		H A PHOTOCOPY OF BOTH SID	ES OF INSUR	ANCE CARD. IF FAMILY HAS	NO MEDICA	AL INS	SURANCE, STATE "NONE."	
		rgency, notify:		-				
Home p	hone _		Business p	hone	Cell pho	ne		
Alternate	e conta	ıct		Alternate's	s phone			
HEALTH	HISTOF	RY						
Are you	now, o	r have you ever been treated for a	ny of the follow	wing:		Α	llergies or Reaction to:	
Yes	No	Condition		Explain		cation		
		Asthma Last attack:			Food	l, Plant	ts, or Insect Bites	
		Diabetes Last HbA1c:						
		Hypertension (high blood pressu	ıre)				Immunizations:	
		Heart disease (e.g., CHF, CAD,	MI)		The f	ollowin	g are recommended by the BSA.	
		Stroke/TIA					munization is required and must	
		Lung/respiratory disease					received within the last 10 years. I e, put "D" and the year. If immunized	
		Ear/sinus problems					ox and the year received.	
		Muscular/skeletal condition			Yes	No	Date	
		Menstrual problems (women on				Tetanus		
		Psychiatric/psychological and					Pertussis	
		emotional difficulties Behavioral disorders (e.g., ADD					Diphtheria	
		ADHD, Asperger syndrome, aut					Measles	
		Bleeding disorders					Mumps	
		Fainting spells Thyroid disease Kidney disease Sickle cell disease					Rubella	
							Chicken pox	
		Seizures Last seizure:					Hepatitis A Hepatitis B	
		Sleep disorders (e.g., sleep apr	iea) Use	CPAP: Yes □ No □			Influenza	
		Abdominal/digestive problems			— = =		Other (i.e., HIB)	
		Surgery Serious injury				emntic	on to immunizations claimed	
		Other				(form required).		
this par	medic rt of th	ations currently used. (If additi e health form.) Inhalers and Ep occasional or emergency use	oiPen informa		às w	ell as t	information about immunizations the immunization exemption form ng Safely on Scouting.org.)	
Media	ation		Medication		Madia	ation		
				Frequency				
			e date started		Approximate date started			
				nedication			nedication	
					_			
Medication			Medication		Medica	ation		
Strength Frequency				Strength Frequency			Frequency	
Approximate date started			_	Approximate date started			Approximate date started	
Reason for medication			Reason for medication			Reason for medication		

Administration of the above medications is approved by (if required by your state): _

Parent/guardian signature and/or MD/DO, NP, or PA signature

Part B

INFORMED CONSENT AND HOLD HARMLESS/RELEASE AGREEMENT

High-adventure base participants:									
xpedition/crew No.:									
staff position:									

I understand that participation in Scouting activities involves a certain degree of risk and can be physically, mentally, and emotionally demanding. I also understand that participation in these activities is entirely voluntary and requires participants to abide by applicable rules and standards of conduct.

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 protected health information to the adult in charge, camp medical staff, camp management, and/or any physician or health care provider involved in providing medical care to the participant. Protected Health Information/Confidential Health Information (PHI/CHI) under the Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. §§160.103, 164.501, etc. seq., as amended from time to time, includes examination findings, test results, and treatment provided 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.

I have carefully considered the risk involved and give consent for myself and/or my child to participate in these activities. I approve

the sharing of the information on this form with BSA volunteer require special consideration for the safe conducting of Scout	s and professionals who need to know of medical situations that might ing activities.
I release the Boy Scouts of America, the local council, the action organizations associated with the activity from any and all claim	vity coordinators, and all employees, volunteers, related parties, or other ms or liability arising out of this participation.
☐ Without restrictions.	
☐ With special considerations or restrictions (list)	
TALENT RELEASE AGREEMENT	
film/videotapes/electronic representations and/or sound recor	ts of America the right and permission to use and publish the photographs dings made of me or my child at all Scouting activities, and I hereby ity coordinators, and all employees, volunteers, related parties, or other ility from such use and publication.
	roadcast, electronic storage, and/or distribution of said photographs/dings without limitation at the discretion of the Boy Scouts of America, ave for any of the foregoing.
☐ Yes ☐ No	
ADULTS AUTHORIZED TO TAKE YOUTH TO AND FROM EVENTS:	
You must designate at least one adult. Please include a telephone	e number.
1. Name	Telephone
2. Name	Telephone
3. Name	Telephone
Adults NOT authorized to take youth to and from events:	
1. Name	
2. Name	
3. Name	
for participation in any event or activity.	found to be inaccurate, it may limit and/or eliminate the opportunity
understand the risk advisories explained in Part D, including that the participant will not be allowed to participate in app	ter, Northern Tier, or Florida Sea Base: I have also read and ng height and weight requirements and restrictions, and understand plicable high-adventure programs if those requirements are not met. nture activities described, except as specifically noted by me or the
Participant's name	
Participant's signature	Date
Parent/guardian's signature	Date
Second parent/guardian signature	(if participant is under the age of 18) Date
Coocha parenti guardian dignature	(if required; for example, CA)
This Annual Health and Medical Record is valid for 12 cale	ndar months.
Part B Full name:	DOB: 680