PERSONAL HEALTH AND MEDICAL RECORD FORM–CLASS 3

BOY SCOUTS OF AMERICA

PLEASE TYPE OR PRINT.

All Class 3 activities require a health examination within the past 12 months by a physician. This includes youth members participating in high-adventure activities, athletic competition, and national or world jamborees. This form is to be used by adults over 40 for all activities requiring a physical examination.

NAME ______________ UNIT ______

NOTE: Keep original form for your personal record. Make repoductions 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.

I. IDENTIFICATION

Age_______ Sex_____ Date of Birth* [ ][ ][ ][ ][ ][ ]

Name ____
Last Name First Name Initial

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 [ ][ ][ ] [ ][ ][ ] [ ][ ][ ][ ]

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.

☐ 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 regular medicine 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 physician 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 judgement of medical personnel dictates.

Parent or Guardian ____________________
(Must sign if applicant is under 18)

Applicant's Signature ____________________

Date signed ____________________

IV. IMMUNIZATIONS

	Last Year Given
TETANUS	______
DIPTHERIA	______
POLIO	______
______	______

Has had	Vaccination	Disease
MEASLES	☐	☐
MUMPS	☐	☐
RUBELLA	☐	☐
PERTUSSIS	☐	☐
CHICKEN POX		☐

Religious preference

V. PHYSICIANS'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 ____________
*(Physician licensed to practice medicine)

*Examinations conducted by doctors of osteopathy, doctors of chiropractic, or pediatric nurse practitioners will be recognized in states where they may perform physical examinations to students enrolled in public school systems.

VI. MEDICAL HISTORY

Parent (or applicant if over 18): Fill in sections I, II, IV and VI *before seeing physician*. 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 applicant since last complete examination.

- Date of most recent complete physical examination (month and year) ____________ 19________
- 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 heath 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
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)	☐	☐	_____	

VII. HEALTH EXAMINATION

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 (under 18) tetanus and diphtheria toxoids, measles, mumps, and rubella vaccines, and trivalent oral polio vaccine are required; adults are required to have tetanus booster within 10 years
- After completing section VII, summarize any restrictions and/or recommendations in sections II and V above, and sign.

DATE ____________________
Ht. ____________ Wt. ____________
B.P. _______ / _______ Pulse ________

VISION: Normal________ Glasses________ Contacts________

HEARING: Normal__________ Abnormal________

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 ____
____
____
____
____
____

LABORATORY: Urinalysis (Dip stick) Albumin____________ Sugar__________

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. No exceptions.

† Trail food is by necessity a high carbohydrate, high caloric 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: Physicians 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.

REVIEW FOR CAMP OR SPECIAL ACTIVITY:

DATE	AGENCY AND ACTIVITY	BY	"OK"	PHYSICIAN RECHECK NEEDED	RESULTS OF RECHECK	INITIAL

INTERVAL RECORD (CAMP, JAMBOREE, TOURNAMENT, TRAVEL, ETC.)

DATE, TIME, PLACE, ETC.	FINDINGS, DIAGNOSES, TREATMENT, INSTRAUCTIONS, DISPOSITION, ETC.	BY: