

# Annual Health and Medical Record

(Valid for 12 calendar months)

## Medical Information

The Boy Scouts of America recommends 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 C** 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 C also includes the parental informed consent and hold harmless/release agreement (with an area for notarization if required by your state) as well as a talent release statement. 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.

**Part B** is required with parts A and C for any event that exceeds 72 consecutive hours, a resident camp setting, or when the nature of the activity is strenuous and demanding, such as service projects, work weekends, or high-adventure treks. It is to be completed and signed by a certified and licensed health-care provider—physician (MD, DO), nurse practitioner, or physician's assistant as appropriate for your state. The level of activity ranges from what is normally expended at home or at school to strenuous activity such as hiking and backpacking. Other examples include tour camping, jamborees, and Wood Badge training courses. It is important to note that the height/weight chart must be strictly adhered to if the event will take the unit beyond a radius wherein emergency evacuation is more than 30 minutes by ground transportation, such as backpacking trips, high-adventure activities, and conservation projects in remote areas.

## 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](http://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.



BOY SCOUTS OF AMERICA

# Commonwealth of Massachusetts Immunization Requirements

105 CMR 430.152

Written documentation of immunization or alternative proof of immunity shall be required for all campers, adults, and staff as follows:

## For Campers and Staff under 18 Years Old

- 1) **Measles, Mumps and Rubella (MMR) Vaccine:** A minimum of one dose of MMR vaccine(s) must be administered at or after 12 months of age. A second dose of live measles containing vaccine given at least four weeks after the first, is required for all campers and staff, who will be entering grades K-12 or college in the school year immediately following the camp session (or in case of an ungraded classroom or the camper/staff does not attend school/college, campers or staff five years of age or older). Laboratory evidence of immunity is acceptable.
- 2) **Polio Vaccine:** A minimum of three doses of either inactivated polio vaccine (IPV) or oral polio vaccine (OPV) are required. If a mixed (IVP/OPV) schedule was used, four doses are required;
- 3) **Diphtheria and Tetanus Toxoids and Pertussis Vaccine:** A minimum of four doses of DTaP/DTP/DT or at least three doses of Td is required. Where a camper or staff person is seven or more years of age and requires additional immunizations to satisfy 105 CMR 430.152(A)(3), Td is to be substituted for DTaP, DTP or DT vaccine. Effective January 1, 2004, a booster dose of Td is required for all campers and staff who will be entering grades seven through ten (or in the case of an ungraded classroom or the camper or staff does not attend school, campers or staff 12 through 15 years of age) if it has been more than five years since the last dose of DTaP/DTP/DT. For all campers and staff who will be entering grades 11 and 12 (or in the case of an ungraded classroom or the camper or staff does not attend school, campers or staff 16 through 17 years of age) a booster of Td is required if it has been more than ten years since the last dose of DTaP/DTP/DT/Td.
- 4) **Hepatitis B:** For all children born on or after January 1, 1992, three doses of Hepatitis B vaccine are required. Laboratory evidence of immunity is acceptable.

## For Staff and Adults 18 Years of Age or Older

- 1) **Measles Vaccine:** Unless born before 1957, two doses of live measles-containing vaccine administered at/or after 12 months of age (at least four weeks apart) are required. Laboratory evidence of immunity is acceptable.
- 2) **Mumps Vaccine:** Unless born before 1957, at least one dose of mumps vaccine administered at/or after 12 months of age is required. Laboratory evidence of immunity is acceptable.
- 3) **Rubella Vaccine:** Unless born before 1957, at least one dose of rubella vaccine administered at/or after 12 months of age is required. Laboratory evidence of immunity is acceptable.
- 4) **Diphtheria and Tetanus Toxoids:** At least three doses of DTaP/DTP/DT/Td are required. A booster dose of tetanus/diphtheria, adult type toxoid (Td) is required if more than ten years have elapsed since the last dose of DTaP/DTP/DT/Td vaccine.

## Physical Examinations or Immunizations Excepted (105 CMR 430.153)

- 1) **Religious Exceptions:** If a camper or staff member has religious objections to physical examinations or immunizations, the camper or staff member shall submit a written statement, signed by a parent or legal guardian for those under 18 years of age, to the effect that the individual is in good health and stating the reason for such objections.
- 2) **Immunizations Contraindicated:** Any immunization specified in 105 CMR 430.152 shall not be required if the health history required by 105 CMR 430.151 includes a certification by a physician that he or she has examined the individual and that, in the physician's opinion, the physical condition of the individual is such that his or her health would be endangered by such immunization.

# Annual BSA Health and Medical Record

## Part A

### GENERAL INFORMATION

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. \_\_\_\_\_

**ATTACH A PHOTOCOPY OF BOTH SIDES OF INSURANCE CARD (SEE PART C).  
 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 ever 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"/>	Chicken pox _____
<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 _____

Exemption to immunizations claimed.  
**(For more information about immunizations, as well as the immunization exemption form, see Scouting Safely on Scouting.org.)**

### MEDICATIONS This section not for use at Camp Resolute - Use separate authorization form.

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.

Medication _____ Strength _____ Frequency _____ Reason for medication _____ Approximate date started _____ Temporary <input type="checkbox"/> Permanent <input type="checkbox"/>	Medication _____ Strength _____ Frequency _____ Reason for medication _____ Approximate date started _____ Temporary <input type="checkbox"/> Permanent <input type="checkbox"/>	Medication _____ Strength _____ Frequency _____ Reason for medication _____ Approximate date started _____ 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.**

Emergency contact No.:

Allergies:

DOB:

Last name:

**Part B**

**PHYSICAL EXAMINATION**

Height \_\_\_\_\_ Weight \_\_\_\_\_ Meets height/weight limits  Yes  No Blood pressure \_\_\_\_\_ Pulse \_\_\_\_\_

Individuals desiring to participate in any high-adventure activity or events in which emergency evacuation would take longer than 30 minutes by ground transportation will not be permitted to do so if they exceed the weight limit as documented at the bottom of this page. Enforcing the height/weight limit is strongly encouraged for all other events, but it is not mandatory. (For healthy height/weight guidelines, visit [www.cdc.gov](http://www.cdc.gov).)

	Normal	Abnormal	Explain Any Abnormalities	Range of Mobility	Normal	Abnormal	Explain Any Abnormalities
Eyes				Knees (both)			
Ears				Ankles (both)			
Nose				Spine			
Throat							
Lungs				<b>Other</b>	<b>Yes</b>	<b>No</b>	
Heart				Contacts			
Abdomen				Dentures			
Genitalia				Braces			
Skin				Inguinal hernia			<b>Explain</b>
Emotional adjustment				Medical equipment (i.e., CPAP, oxygen)			

**Allergies** (to what agent, type of reaction, treatment):

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I certify that I have, today, reviewed the health history, examined this person, and approve this individual for participation in:

- Hiking and camping     Competitive activities     Backpacking     Swimming/water activities     Climbing/rappelling
- Sports     Horseback riding     Scuba diving     Mountain biking     Challenge ("ropes") course
- Cold-weather activity (<10°F)     Wilderness/backcountry treks

Specify restrictions (if none, so state)

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**Certified and licensed health-care providers recognized by the BSA to perform this exam include physicians (MD, DO), nurse practitioners, and physician's assistants.**

- To Health Care Provider:** Restricted approval includes:
- Uncontrolled heart disease, asthma, or hypertension.
  - Uncontrolled psychiatric disorders.
  - Poorly controlled diabetes.
  - Orthopedic injuries not cleared by a physician.
  - Newly diagnosed seizure events (within 6 months).
  - For scuba, use of medications to control diabetes, asthma, or seizures

Provider printed name \_\_\_\_\_  
 Signature \_\_\_\_\_  
 Address \_\_\_\_\_  
 City, state, zip \_\_\_\_\_  
 Office phone \_\_\_\_\_  
 Date \_\_\_\_\_

Height (inches)	Recommended Weight (lbs)	Allowable Exception	Maximum Acceptance
60	97-138	139-166	166
61	101-143	144-172	172
62	104-148	149-178	178
63	107-152	153-183	183
64	111-157	158-189	189
65	114-162	163-195	195
66	118-167	168-201	201
67	121-172	173-207	207
68	125-178	179-214	214
69	129-185	186-220	220

Height (inches)	Recommended Weight (lbs)	Allowable Exception	Maximum Acceptance
70	132-188	189-226	226
71	136-194	195-233	233
72	140-199	200-239	239
73	144-205	206-246	246
74	148-210	211-252	252
75	152-216	217-260	260
76	156-222	223-267	267
77	160-228	229-274	274
78	164-234	235-281	281
79 & over	170-240	241-295	295

This table is based on the revised Dietary Guidelines for Americans from the U.S. Dept. of Agriculture and the Dept. of Health & Human Services.

**Part B** Last name: \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Part C**

**Informed Consent and Hold Harmless/Release Agreement**

I understand that participation in Scouting activities involves 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 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.

- Without restrictions.
- With special considerations or restrictions (list)

**Talent Release Form**

I hereby assign and grant to the local council and the Boy Scouts of America the right and permission to use and publish the photographs/film/videotapes/electronic representations and/or sound recordings made of me or my child by the Boy Scouts of America, and I hereby release the Boy Scouts of America from any and all liability from such use and publication.

I hereby authorize the reproduction, sale, copyright, exhibit, broadcast, electronic storage, and/or distribution of said photographs/film/videotapes/electronic representations and/or sound recordings without limitation at the discretion of the Boy Scouts of America, and I specifically waive any right to any compensation I may have for any of the foregoing.

- Yes     No

**I understand that, 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 \_\_\_\_\_

Parent/guardian's signature \_\_\_\_\_  
(if under the age of 18)

Date \_\_\_\_\_

**Attach copy of insurance card (front and back) here. If required by your state, use the space provided here for notarization.**



BOY SCOUTS OF AMERICA  
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<http://www.scouting.org>



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**Part C**    **Last name:** \_\_\_\_\_    **DOB:** \_\_\_\_\_

**Camp Resolute**  
**Authorization to Administer Medication to a Camper**  
**(To be completed and submitted with medical form)**

I hereby authorize E. Paul Robsham Scout Reservation to administer to my child;

\_\_\_\_\_ the medications listed below in accordance with 105 CMR 430.160.  
 (Name of Child)

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

Medication _____ Strength _____ Frequency _____ Reason for medication _____ _____ Approximate date started _____ Temporary <input type="checkbox"/> Permanent <input type="checkbox"/>	Medication _____ Strength _____ Frequency _____ Reason for medication _____ _____ Approximate date started _____ Temporary <input type="checkbox"/> Permanent <input type="checkbox"/>
Medication _____ Strength _____ Frequency _____ Reason for medication _____ _____ Approximate date started _____ Temporary <input type="checkbox"/> Permanent <input type="checkbox"/>	Medication _____ Strength _____ Frequency _____ Reason for medication _____ _____ Approximate date started _____ Temporary <input type="checkbox"/> Permanent <input type="checkbox"/>
Medication _____ Strength _____ Frequency _____ Reason for medication _____ _____ Approximate date started _____ Temporary <input type="checkbox"/> Permanent <input type="checkbox"/>	Medication _____ Strength _____ Frequency _____ Reason for medication _____ _____ Approximate date started _____ Temporary <input type="checkbox"/> Permanent <input type="checkbox"/>

**NOTE: Be sure to bring medications in the original containers, and make sure that they are not expired, including inhalers and EpiPens. You should not stop taking any maintenance medication.**

105 CMR 430.160(A)

*Medication prescribed for campers shall be kept in original containers bearing the pharmacy label, which shows the date of filling, the pharmacy name and address, the filling pharmacist's initials, the serial number of the prescription, the name of the patient, the name of the prescribing practitioner, the name of the prescribed medication, directions for use and cautionary statements, if any, contained in such prescription or required by law, and if tablets or capsules, the number in the container. All over the counter medications for campers shall be kept in the original containers containing the original label, which shall include the directions for use.*

105 CMR 430.160(C)

*Medication shall only be administered by the health supervisor or by a licensed health care professional authorized to administer prescription medications. The health care consultant shall acknowledge in writing the list of medications administered at the camp. If the health supervisor is not a licensed health care professional authorized to administer prescription medications, the administration of medications shall be under the professional oversight of the health care consultant. Medication prescribed for campers brought from home shall only be administered if it is from the original container, and there is written permission from the parent/guardian.*

105 CMR 430.160(D)

*When no longer needed, medications shall be returned to a parent or guardian whenever possible. If the medication cannot be returned, it shall be destroyed.*

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_