

NAME: _____

UNIT: _____

Bucks County Council, Boy Scouts of America
One Scout Way, Doylestown PA 18901

PERSONAL HEALTH AND MEDICAL RECORD FORM—Class

3

I. IDENTIFICATION

AGE _____ SEX _____

_____|_____|_____|_____|_____|_____|
Date of Birth

NAME: _____
Last Name First Name Initial Mo. Day Year

ADDRESS: _____

CITY & STATE _____
ZIP _____



HEALTH/ACCI—
DENT INSURANCE _____ POLICY NO. _____

IN AN EMERGENCY NOTIFY:

Name _____ relationship _____
Address _____ (H) phone _____
City & State _____ (W) phone _____

BOY SCOUTS OF AMERICA

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 competitions, and world jamborees. Annually, this form is to be used by adults over 40 for all activities requiring a physical examination and applies to all Wood Badge participants/staff regardless of age.

II. EMERGENCY MEDICAL INFORMATION:

- 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 below.

To the best of my knowledge, the information in sections I, II, III, IV and V, is accurate and complete. I request a licensed health-care practitioner to examine applicant, to give needed immunizations, 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 18 or younger)

APPLICANT'S SIGNATURE _____
Date signed _____

IV. IMMUNIZATIONS:

If disease, put "D" and year.

	Last Year Given
Tetanus	_____
Diphtheria	_____
Partussis	_____
Measles	_____
Rubella	_____
Polio	_____
Chicken Pox	_____
Religious preference	_____

V. LICENSED HEALTH-CARE PRACTITIONER'S EVALUATION AND ADVICE:

APPROVED FOR PARTICIPATION IN:

- Hiking and camping Competitive sports
- Water activities All activities

Specify exceptions _____

RECOMMENDATIONS: (Explain any restrictions OR limitations) _____

SIGNED _____
*Licensed health-care practitioner

*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.

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) _____
- 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
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

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 (afloat or on land) 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 that 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 _____	HEARING Normal _____
Ht. _____ Wt. _____	Glasses _____	Abnormal _____
B.P. _____ / _____ Pulse _____	Contacts _____	

Check line if normal; circle if abnormal and give details below:

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

COMMENTS _____