

# 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 enter 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 _____

Exemption to immunizations claimed.

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

### 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.

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**

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**

**Parental 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 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.**



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