YOUTH HEALTH HISTORY & MEDICAL EVALUATION

Form No. 2005Y

THIS FORM IS *NOT* TO BE USED BY ADULTS.

1. If your child has had a medical evaluation (physical exam) within the last 36 months, a copy of the results of this examination must be attached to the health history portion of this form for all participants in a summer camping experience.
2. If a copy is not available, a physical exam using the medical evaluation section on the back of this form must be performed ***this year prior to camp*** by a licensed medical practitioner.*
3. A physical exam this year prior to camp is also required if your child is currently under medical care, takes a prescribed medication, requires a medically prescribed diet, has had an injury or illness during the past 6 months that limited activity for a week or more, has ever lost consciousness during physical activity, or suffered a concussion from a head injury.

* 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.

HEALTH HISTORY

To be ***filled out and signed annually*** by parent or guardian.

IDENTIFICATION To be filled out by parent, guardian, or adult participant. Please print in ink.

Name ______ Date of birth ______ Age ______ Sex ______

Name of parent or guardian ______ Telephone ______

Home address ______ City ______ State ______ Zip ______

Business address ______ City ______ State ______ Zip ______

If person named above is not available in the event of an emergency, notify

Name ______ Relationship ______ Telephone ______

Name ______ Relationship ______ Telephone ______

Name of personal physician ______ Telephone ______

Personal health/accident insurance carrier ______ Policy No. ______

Check all items that apply, **past or present**, to your health history. Explain any “Yes” answers.

ALLERGIES: Food, medicines, insects, plants Yes ☐ No ☐ Explain: ______

GENERAL INFORMATION:

	Yes	No		Yes	No
Asthma	☐	☐	Heart trouble	☐	☐
Cancer/leukemia	☐	☐	Hemophilia	☐	☐
Convulsions/seizures	☐	☐	High blood pressure	☐	☐
Diabetes	☐	☐	Kidney disease	☐	☐

Explain: ______

List any medications to be taken at camp: ______

List any physical or behavioral conditions that may affect or limit full participation in swimming, backpacking, hiking long distances, or playing strenuous physical games: ______

List equipment needed such as wheelchair, braces, glasses, contact lenses, etc. ______

Immunizations: (give date of last inoculation)

Tetanus toxoid ______ Measles ______ Polio ______

Diphtheria ______ Mumps ______ ______

Pertussis ______ Rubella ______ ______

I give permission for full participation in BSA program, subject to limitations noted herein.

In case of emergency, I understand every effort will be made to contact me. In the event I cannot be reached, I hereby give my permission to the physician selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child. I give permission for images of my child to be used in print and web publications that promote council camping facilities.

Date ______ X ______

Signature of parent or guardian

MEDICAL EVALUATION

Read all requirements outlined on the top of page 1

Name ______________________________ Age ________

NOTE TO LICENSED MEDICAL PRACTITIONERS*: The person being evaluated will be attending 1 or more weeks of camp that may include sleeping on the ground and participating in strenuous activities such as hiking, boating, and vigorous group games. Please review the HEALTH HISTORY with the participant for any interim changes. Explain any “abnormal” evaluations.

PHYSICAL EXAMINATION (To be filled out by a licensed medical practitioner)

Height ____________ Weight ____________ BP ______ / ______ Pulse ____________

Lab: Urinalysis (dipstick) ____________ Albumin ____________ Sugar ____________

VISION: Normal ____________ Glasses ____________ Contacts ____________

HEARING: Normal ____________ Abnormal ____________ Explain ____________

Check box:

	N	Abn		N	Abn		N	Abn
Growth development	☐	☐	Teeth	☐	☐	Genitalia	☐	☐
Skin	☐	☐	Cardiopulmonary system	☐	☐	Musculoskeletal	☐	☐
HEENT	☐	☐	Hernia	☐	☐	Neurobehavioral	☐	☐

Explain ______________________________

____

____

LIMITATIONS

Activity restrictions ______________________________

Diet restrictions ______________________________

Signature ______________________________ M.D./D.O./D.C./P.A./R.N.P.* Date ____________

Address ______________________________ Phone ____________

City, State, ZIP ______________________________

*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.

INTERVAL RECORD	SCREENING EXAMINATION	
DATE, TIME, PLACE, ETC.	(Findings, diagnoses, treatment, instructions, disposition, etc.)	BY

A PHOTOCOPY OF THIS FORM IS PERMITTED

NAME ____________

TROOP ____________

CAMPSITE ____________