

**PERSONAL HEALTH AND MEDICAL RECORD FORM—CLASS 3**

**I. IDENTIFICATION** Age \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth\* 

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Name \_\_\_\_\_  
Last Name First Name Initial

Address \_\_\_\_\_

City & State \_\_\_\_\_ ZIP \_\_\_\_\_

Health/Accident Insurance \_\_\_\_\_ Policy No. \_\_\_\_\_

**IN AN EMERGENCY NOTIFY:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Home Phone 

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City & State \_\_\_\_\_ Business Phone 

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Personal Physician \_\_\_\_\_ Phone 

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**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	_____
DIPHTHERIA	_____
POLIO	_____

Has had Vaccination Disease

MEASLES	<input type="checkbox"/>	<input type="checkbox"/>
MUMPS	<input type="checkbox"/>	<input type="checkbox"/>
RUBELLA	<input type="checkbox"/>	<input type="checkbox"/>
PERTUSSIS	<input type="checkbox"/>	<input type="checkbox"/>
CHICKEN POX	<input type="checkbox"/>	<input type="checkbox"/>

Religious preference \_\_\_\_\_

**BOY SCOUTS OF AMERICA**

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.

**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** \_\_\_\_\_

**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.

**PLEASE TYPE OR PRINT.**

**NOTE:** Keep original form for your personal record. Make reproductions 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.

NAME \_\_\_\_\_

UNIT \_\_\_\_\_

**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 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	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Serious Injury	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Deformity	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Skin, glands	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Ears, eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Nose, sinus	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Teeth, tonsils	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Dentures	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Bridge	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Chest, lungs	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Heart	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Murmur	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Stomach, bowels	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Appendicitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Kidneys or urine	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Albumin	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Sugar	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Infection	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Bed-wetting	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Menstrual problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Hernia (rupture)	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Back, limbs, joints	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Sleepwalking	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Nervous condition	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Other (explain)	<input type="checkbox"/>	<input type="checkbox"/>	_____	

**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 (afloat 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 \_\_\_\_\_ VISION: Normal \_\_\_\_\_ HEARING: Normal \_\_\_\_\_

Ht. \_\_\_\_\_ Wt. \_\_\_\_\_ Glasses \_\_\_\_\_ Abnormal \_\_\_\_\_

B.P. \_\_\_\_\_ / \_\_\_\_\_ Pulse \_\_\_\_\_ Contacts \_\_\_\_\_

- Check box if normal, circle if abnormal and give details below:
- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Growth, development | <input type="checkbox"/> Teeth, tonsils         | <input type="checkbox"/> Genitourinary    |
| <input type="checkbox"/> Skin, glands, hair  | <input type="checkbox"/> Respiratory            | <input type="checkbox"/> Skeletomuscular  |
| <input type="checkbox"/> Head, neck, thyroid | <input type="checkbox"/> Cardiovascular         | <input type="checkbox"/> Neuropsychiatric |
| <input type="checkbox"/> Eyes, ears, nose    | <input type="checkbox"/> Abdomen, hernia, rings | <input type="checkbox"/> 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, INSTRUCTIONS, DISPOSITION, ETC.	BY: