

HEART OF AMERICA COUNCIL, BSA
PERSONAL HEALTH HISTORY
 CLASS 1

Class 1 (update annually for all participants). Form required for the following activities: Overnight hike, resident camp; with level of activity similar to that of home or school. Medical care should be readily available. Current personal health and medical summary (history) is attested by parent/guardian or adult participant. This form must be filled out by all participants annually and be on file in first aid lodge for easy reference.

CLASS 1 PERSONAL HEALTH AND MEDICAL HISTORY
 (Completed annually by all participants)

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

IDENTIFICATION

Name _____ Date of birth _____ Age _____ Sex _____
 Home address _____ City _____ State _____ ZIP _____
 Name of parent or guardian _____ Telephone _____
 Business address _____ City _____ State _____ ZIP _____
 Business Phone Number _____ Personal Physician _____ Telephone _____
 If person named above is not available in the event of an emergency, notify:
 Name _____ Relationship _____ Telephone _____
 Name _____ Relationship _____ Telephone _____
 Personal health/accident insurance carrier _____ Policy No. _____

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

LIST ALLERGIES: (Plants, food, medicines, insects, Other):

MEDICINES TO BE TAKEN AT CAMP AND DOSAGE:

- 1.
- 2.
- 3.

GENERAL INFORMATION:	Yes	No		Yes	No		Yes	No
Attention Deficit	_____	_____	Diabetes	_____	_____	Asthma	_____	_____
Cancer/Leukemia	_____	_____	Heart Trouble	_____	_____	Kidney Disease	_____	_____
Convulsions	_____	_____	Hemophilia	_____	_____	High blood pressure	_____	_____

- Explain any above "yes" answers
1. List any physical or behavioral conditions that may affect or limit full participation in swimming, backpacking, hiking long distances, or playing strenuously physical games
 2. List any equipment needed (wheelchair, braces, glasses, contacts, etc.)

IMMUNIZATIONS: (Exact dates needed - Do not write "Up to DATE" or "Current")

Tetanus toxoid _____ Measles _____ Polio _____
 Diphtheria _____ Mumps _____ Hep B _____
 Pertussis _____ Rubella _____

TREATMENT AUTHORIZATION

PARENT/GUARDIAN OF SCOUT OR ADULT (18-39) PLEASE READ AND SIGN BELOW

The information provided on this form is correct to the best of my knowledge. In the event of an emergency, if persons listed on the above as emergency contacts cannot be reached, I hereby give permission to the physician selected by the adult leader in charge to secure proper treatment, which may include anesthesia, surgery, or injections of medication.

Date _____ Signature of parent/guardian or adult participant _____

Name _____ Troop _____ Dist _____ Camp _____ Campsite _____ Sess _____

CLASS 2 MEDICAL EVALUATION
(Read additional requirements outlined on front of form)

Name _____ Age _____
Last First Middle initial

Class 2 (required once every 36 months for all participants under 40 years of age). Activity: Any overnight stay at resident camp or any other activity such as backpacking, tour camping, or recreational sports involving events lasting longer than 72 consecutive hours, with level of activity similar to that at home or school. Medical care is readily available.

For participants who have had a medical evaluation (**physical examination**) within the last 36 months, a copy of the results of this examination must be attached to the health history for all participants in a camping experience lasting longer than 72 consecutive hours (3 days and nights). If a copy is not available, a physical examination (using the Class 2 section of this form) must be scheduled by a licensed medical practitioner*. **This medical evaluation (physical examination) also is required if participant 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.**

*Conducted by medical doctors and doctors of osteopathy.

NOTE TO LICENSED MEDICAL PRACTITIONER: 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 "abnormal" evaluations.**

MEDICAL EXAMINATION (To be filled out by a licensed M.D./D.O.)

Height _____ Weight _____ BP _____/_____ Pulse _____
Lab: Urinalysis [if indicated (dipstick)] Albumin _____ Sugar _____
VISION: Normal _____ Glasses _____ Contacts _____
HEARING: Normal _____ Abnormal _____ Explain _____

Check box:	N	Abn		N	Abn		N	Abn
Growth development	_____	_____	Neurobehavioral	_____	_____	Teeth	_____	_____
Cardiopulmonary sys.	_____	_____	HEENT	_____	_____	Hernia	_____	_____
Musculoskeletal	_____	_____	Skin	_____	_____	Genitalia	_____	_____

Explain: _____

LIMITATIONS

Activity restrictions _____
Diet restrictions _____

Signature _____ M.D./D.O. License No. _____
Signature _____ P.A./R.N.P.(see note below)
Date _____
Address _____ Phone _____
City/State/ZIP _____

NOTE: If this exam is performed by a Physician's Assistant or Registered Nurse Practitioner, under the Collaborative Practice Act, the name of such Co-Practicing Physician must also appear on this form.