



Tall Pine Council, #264 Boy Scouts of America



Health and Medical Record

(for use by all campers 17 years of age and under)

PLEASE PRINT OR TYPE THE FOLLOWING INFORMATION

Signatures are required on pages three and four of this form

Name:		Birth:		Age:		Sex:	<input type="checkbox"/> M <input type="checkbox"/> F
Street:				Phone:	()		
City:		State:		Zip:			
Parent / Guardian Name(s):				Parent / Guardian Phone:	()		
Council or Organization:		Unit #:		<input type="checkbox"/> Pack <input type="checkbox"/> Troop <input type="checkbox"/> Crew <input type="checkbox"/> Post <input type="checkbox"/> Other: _____			

In case of emergency, notify:

Name:		Relationship:	
Address:			
Primary Phone:	()	Alternate Phone:	()

or, if they cannot be contacted, contact the following:

Name:		Relationship:	
Primary Phone:	()	Alternate Phone:	()

Physician Name:		Physician Phone:	()
Health Insurance Company:		Policy Number:	

Current Medications

- This camper takes no medications on a routine basis.
- This camper takes medication as follows: *(Attach additional pages if this camper takes more than four (4) medications, or if additional space is needed to provide complete administration details, or reasons for the medication)*

	Medication Name	Dosage	Frequency/Time Taken
1			
Reason:			
2			
Reason:			
3			
Reason:			
4			
Reason:			

During the school year, this camper takes the following medication(s) which he/she does NOT take during the summer:

Reason:		

Name: _____

Unit: _____

Campsite: _____

Age: _____

Name:		Unit #	
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HEALTH HISTORY

Indicate any problems of the following areas/natures, which you have had or currently have
Provide year of occurrence/diagnosis and complete details for each yes answer, below or on a separate page

Yes	Year	Ailment	Yes	Year	Ailment	Yes	Year	Ailment
		Appendicitis			Fainting Spells			Nervous Condition
		Asthma			Food Allergies			Nose/Sinus
		Back/Limbs/Joints			Glasses/Contacts			Plant Allergies
		Bed Wetting			Hay Fever			Rheumatic Fever
		Blood Pressure			Heart			Serious Illness
		Cancer/Leukemia			Hemophilia			Serious Injury
		Chest/Lungs			HIV / AIDS			Skin/Glands
		Convulsions			Infectious Diseases			Sleep Walking
		Deformity			Insect Allergies			Stomach/Bowels
		Dentures			Kidney/Urine			Surgery
		Diabetes			Medication Allergies			Teeth/Tonsils
		Ears/Eyes			Menstrual Problems			Tuberculosis

Other allergies or reactions to any medications, please specify:

Details:

Please answer the following, and provide complete details for any YES answers below or on a separate page

YES	NO	Do you tire easily?
YES	NO	Do you get out of breath easily?
YES	NO	Have you had more than a brief minor illness or injury during the past year?
YES	NO	Do you have any condition now requiring regular medication or treatment?
YES	NO	Have you had any operations or serious injuries?
YES	NO	Are there any other special health considerations?
YES	NO	Is there any reason to restrict any activities?
YES	NO	Are there any behavior / emotional conditions which need to be considered?
YES	NO	Do you have any communicable diseases?

Please provide complete details for every YES answer above:

Please provide immunization record and date of last inoculation...

Smallpox:		Diphtheria:		Whooping Cough:	
Tetanus:		Typhoid:		Poliomyelitis:	
Hepatitis B		Varicella		BCG	
Mumps:		Measles:		Rubella:	
Chickenpox:		Other, specify:			
Date of Negative TB Test/X-ray*:			*required for staff, see page 3		

Name: _____	Date of Birth: _____	Age: _____
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PHYSICAL EXAMINATION
(to be completed by a Licensed Physician)

Vital Signs:

Height: _____ Weight: _____ Blood Pressure: _____

Pulse: _____ Respiration: _____ Temperature: _____

Vision:

Far: R 20/____ L 20/____ Corrected Uncorrected

	Normal	Abnormal	NOTES / COMMENTS:
Head			
Eyes			
Ears			
Nose			
Mouth/Throat			
Neck			
Chest			
Lungs			
Cardiovascular			
Abdomen			
Hernia			
Genitalia			
Musculoskeletal			
Upper Extremities			
Lower Extremities (incl. feet)			
Back/Spine			
Neurological			
Skin			

Staff is required to provide proof of a negative TB Test within the past 36 months.
(physician certification of this section below will meet this staff requirement)

TB TEST: Positive Negative Date: _____

Assessment:

No Problems Identified

Problems Identified: _____

Recommendations:

Unlimited / Unrestricted Activity

Limit / Restrict Activity as follows: _____

Limit / Restrict Diet as follows: _____

X _____

Physician Signature & Title

Date

License Number

Name:		Unit #	
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Release of Camper from Camp

The following information is required by the Michigan Department of Consumer and Industry Services pursuant to Public Act 116 of 1973 and Administrative Rule 117.(2)(a).

Authorization is granted for the release of the aforementioned individual to adult employees, staff, volunteers, and camp staff of the Tall Pine Council #264, Boy Scouts of America. In addition to the parent(s) or guardian(s) signing this form, only those individuals listed below are authorized to remove the aforementioned individual from camp during their period of camping:

Name:	Relationship ‡

‡ If both parents do not sign this form, the parent who does not sign, must be listed above in order for the camper to be released to that parent.

The Michigan Department of Consumer and Industry Services pursuant to Public Act 116 of 1973 and Administrative Rule 127.1(1) requires the following information.

The health history contained herein is correct so far as I know and the person herein described has permission to engage in all prescribed activities, except as noted by me and/or the examining physician. In the event I cannot be reached in an emergency, I hereby give permission to the medical provider selected by a designated representative of the Boy Scouts of America to authorize emergency medical or surgical treatment, routine non-surgical medical care, hospitalize, secure proper anesthesia, or to order injection(s) for my child. The person herein described is in good health, has all required immunization current, and I assume the health responsibility for the individual.

Year	Parent/Guardian Signature		Parent/Guardian Signature		
1	X		X		authorization is good for one year from earliest date signed
	Print Name	Date	Print Name	Date	
This form may be re-used for up to three years for all campers EXCEPT STAFF					
2	X		X		authorization is good for one year from earliest date signed NOT VALID FOR STAFF
	Print Name	Date	Print Name	Date	
3	X		X		authorization is good for one year from earliest date signed NOT VALID FOR STAFF
	Print Name	Date	Print Name	Date	

THE FOLLOWING ITEMS ARE FOR YOUTH STAFF ONLY

The Michigan Department of Consumer and Industry Services pursuant to Public Act 116 of 1973 and Administrative Rule 109.4 requires the following information

Registered Position in Council:	
Position in Camp:	
Number years/seasons in camp as leader/staff:	
Number years/seasons of short term or weekend scout camping:	

Indicate the date (I) issued or date (E) expired of the following training certifications

Life Saving Merit Badge	I	ARC Lifeguard	E	BSA Nat'l Camp School	I
BSA Lifeguard	I	CPR-BLS Certified	I	ARC Multi media 1 st Aid	I
ARC Basic Water Safety	I	Safe Swim Defense	I	ARC Advanced 1 st Aid	I
ARC Advanced Swimmer	I	Water Safety Instructor	E	ARC Life Guard Instructor	E

Have you ever been convicted of anything other than a minor traffic violation?

yes no

(you must attach a complete explanation for a YES answer)

Staff Member Signature: X _____

Date: _____

As the representative for the Chartering Organization or the related BSA Council, I recommend the above-identified individual to serve as a leader of our Scouts in Camp.

X _____
Unit Comm'r; Scout Coord; Head of Chartered Org.

X _____
Council Representative