

Name: _____ Troop #: _____ Campsite: _____



ADULT PERSONAL HEALTH and MEDICAL RECORD CLASS 2 REVISED

First

Dear Scout Leader:

We need the information requested in this form for your safety and the safety of the Scouts you are camping with. We also want to eliminate the cost of unnecessary visits to your physician.

Northern Star Council/BSA and the State of Wisconsin require that:

Adult campers over 18 and under 40 years of age have a medical evaluation by a licensed physician within **the last 36 months**, attested to by a medical doctor.

Adult campers over 40 years of age must have a medical evaluation within the last 12 months.

This form **MUST BE UPDATED AND SIGNED EACH YEAR BY YOU** - regardless of the date of physical exam.

Last Name

Name: _____

MUST BE COMPLETED BY ADULT CAMPER

1. Have you had a medical evaluation (physical examination) within the last:
36 months if 18-40 years old or 12 months if over 40 years old?

Yes - Date of last exam: Month: _____ Year: _____.

Clinic Name: _____ Phone # (____) _____

No - Please complete pages 2 & 3, and then complete a physical examination with a physician currently licensed to practice medicine. The doctor should complete the medical evaluation found on page 4.

2. Have you had a **tetanus shot** in the last 10 years?

Yes -Please **write the date** you received your last immunization on page 3.

No - Please schedule an appointment with a physician to receive a tetanus inoculation (or booster) at least 2 weeks before you attend camp. Be sure to indicate the date you received the tetanus shot on page 3.

3. Have you been told by a physician that you should not participate in **strenuous activities**?

No -

Yes - Please write on page 3 what specific limitations you have so the medical staff is aware of them.

4. Are you **currently being treated** by a physician?

No -

Yes - Please provide a statement from your physician indicating what current treatment is being given. This may be in the form of a letter or use page 4 of this form.

5. Are you taking prescribed medication regularly?

No -

Yes - Please provide a statement from your physician indicating present prescribed medicine, including how, why and when it should be administered while you are in camp.

6. Are you on a **prescribed meal plan**?

No -

Yes - Please provide a copy of your diet to assist our commissary in preparing meals to meet your needs.

7. Have you **lost consciousness** during physical activity or had a concussion due to a head injury?

No -

Yes - Please provide a current statement from a physician on the injury and current symptoms. This may be a letter, or use page 4 of this form.

8. Have you had an **illness or injury** within the last 6 months that limited your activity longer than one week?

No - **Please sign the lines below.**

Yes -Provide an updated, current medical evaluation from your doctor. Please sign the lines below.

The answers to these questions are **current and correct** to my best knowledge regarding my health:

Print your full name: _____

DATE: _____

Signed _____

For adults under 40 years of age:

"I have reviewed the information on pages 2 & 3 regarding my health, including the emergency treatment statement, and have noted any changes in the last year."

Second year update: _____ Date: _____

Third year update: _____ Date: _____

HEALTH AND MEDICAL SUMMARY

MUST BE COMPLETED by applicant

IDENTIFICATION:

Name _____ Date of Birth _____ Age _____ Sex _____

Name of parent or guardian _____ Telephone (____) _____

Home address _____ City _____ State _____ Zip _____

Daytime/Business Telephone(s) (____) _____

****In the event of an emergency, notify:**

Name _____ Relationship _____ Telephone (____) _____

Name _____ Relationship _____ Telephone (____) _____

Name of personal physician _____ Telephone (____) _____

Name of Clinic _____

Personal Health/Accident insurance carrier _____ Policy # _____

In case of emergency, I understand every effort will be made to with me or the responsible people listed above. In the event I am unable to respond, I hereby give my permission to the physician selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery and injections of medication.

Date: _____ Signature: _____

MEDICAL INFORMATION: past or present (please circle)

Asthma	Yes	No	Diabetes	Yes	No	Hemophilia	Yes	No
Heart Disease	Yes	No	High Blood Pressure	Yes	No	Other: _____	Yes	No
Convulsions	Yes	No	Cancer	Yes	No	_____		

Explanations _____

Any reason to restrict full activity including swimming, long hikes, backpacking, strenuous physical games? Yes No

List any conditions limiting full participation (physical or emotional) _____

ALLERGIES: to Foods, Plants, Insects, Medicines, etc: Yes No Is any allergy severe? Yes No

Explanations _____

MEDICINES:

Are any medicines to be taken at camp? Yes No

List ALL medicines. Send ample supplies and directions for use. _____

Any special equipment such as orthopedic or handicap devices, glasses or contacts, dentures? Yes No

Please list: _____

IMMUNIZATIONS: Please write the date of last inoculation or disease:

*Tetanus Toxoid _____ Polio _____ Mumps _____

Diphtheria _____ Pertussis _____ Measles _____

Chicken Pox _____ Rubella _____

* Mandatory immunization within 10 years

