Name: ______ Last Name ______ First ______ Troop #: ______ Campsite: ______

YOUTH PERSONAL HEALTH and MEDICAL RECORD

CLASS 2 REVISED

Dear Parent or Guardian:

We need the information requested in this form for your Scout's safety.
We also want to eliminate the cost of unnecessary visits to your physician.

The first year this form is used, the medical evaluation on page 4 **should** be filled out **by a physician** (or a copy of a medical evaluation must be attached).

Then, this form MUST BE UPDATED AND SIGNED EACH YEAR (on page 2) by the parent or guardian. Another doctor's evaluation will not be needed until 3 years (36 months) have passed since the date on this form, OR significant change in the Scout's condition mandates re-evaluation and update.

Each year you must include a complete physical form, which has been signed by a physician. You may use the form on page 4 or attach a current physical form.

Northern Star Council/BSA and the State of Wisconsin require that campers have a medical evaluation by a licensed physician within **the last 36 months**, attested to by a medical doctor. Specific conditions may dictate more frequent examination. The health history and emergency information must be updated and signed by the parent EACH YEAR.

MUST BE COMPLETED BY PARENT OR GUARDIAN

1. Has your son had a medical evaluation (physical examination) within the last 36 months?

   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. Has your son had a tetanus shot in the last 10 years?

   Yes -Please write the date your son received his last immunizations on page 3.

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

3. Has a physician told you that your son should not participate in strenuous activities?

   No -

   Yes - Please write on page 3 what specific limitations should be imposed upon your son's activities in camp.

4. Is your son currently be 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. Is your son 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 your son is in camp.

6. Is your son on a prescribed meal plan?

   No -

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

7. Has your son 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. Has your son had an illness or injury within the last 6 months that limited his activity longer than one week?

   No - Please sign the lines below.

   Yes - Schedule a visit with a physician for an updated medical evaluation. Please sign the lines below.

The answers to these questions are current and correct to my best knowledge regarding the health of my son:

Print Scouts full name____

________________________________ ____________________________________DATE:______________

Signed (Boy Scout) Signed (Parent or Guardian)

"I have reviewed the information on pages 2 & 3 regarding my son, 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 parent or guardian

IDENTIFICATION:

Name ________________ Date of Birth __________ Age ______ Sex ______

Name of parent or guardian ________________ Telephone (______)________

Home address ________________ City __________ State ______ Zip ________

Daytime/Business Telephone(s) (____) ________________

**** 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 (______) ________

Name of Clinic ________________

Personal Health/Accident insurance carrier ________________ Policy # ________

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 and injections of medication, for my son.

Date: __________ Signature of parent or guardian: ________________

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**

MEDICAL EVALUATION

To be filled out by physician

Name____ Age ____________

NOTE TO PARENT: It is not necessary to update this Medical Evaluation page each year – unless you answered "no" to question 1 or "yes" to questions 4, 5, or 8 on page 2.

NOTE TO PHYSICIAN: The person being evaluated will be attending one or more weeks of camp that may include sleeping on the ground, participating in strenuous activities such as hiking, boating, and vigorous group games.

PHYSICAL EXAMINATION

Height__________________ Weight__________________ BP __________ / __________

Lab: Urinalysis (dipstick) Albumin __________________ Sugar __________________

VISION: Normal__________ HEARING: Normal__________

Glasses__________ Abnormal__________

Contacts__________

Check box if normal and circle if abnormal

Growth development Ears, nose Heart Musculo skeletal

Skin, glands Teeth, tonsils Hernia Eyes

Thyroid, head, neck Lungs Genitalia Other

EXPLAIN ANY ABNORMAL FINDING____

Limitations:

Activity restrictions: ____

Diet restrictions:____

Signature______________________________M.D./D.O. Date______________

Physician's Name (print/type)____

Clinic Address______________________________ Phone______________

City, State, Zip____

	INTERVAL RECORD	
DATE, TIME, PLACE, ETC	(findings, diagnoses, treatment, instructions, dispositions, etc.)	BY

J:\Class 2 Youth Medical Ledger.doc