



PERSONAL HEALTH & MEDICINAL RECORD FORM



Please keep original and make copies! This form will not be returned!

I. IDENTIFICATION:

Age: _____ Sex: _____ Date Of Birth: ____ / ____ / ____

Name: _____
Last First Middle

Address: _____

City/State: _____ Zip: _____

Health/Accident insurance policy and number:

IN AN EMERGENCY NOTIFY:

Name: _____ Relationship: _____

Address: _____

City/State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Personal Physician: _____ Phone: _____

Religious Preference: _____

II. EMERGENCY MEDICAL INFORMATION:

Has or is subject to (check & give details):

Allergy to medicine, food, plant, animal, insect toxin.
 Any condition that may require special care, medication or diet.

Asthma Convulsions Heart trouble Contact lenses
 Diabetes Fainting Spells Bleeding disorder Dentures

Explain: _____

III. MEDICAL HISTORY:

Parent (or applicant if over 18) fill out sections I, II, III, & IV before seeing a 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 health since last complete examination.

- Date of most recent complete physical examination (mnth & yr) ____ 19____

- Are you aware of any current health problems? No Yes

- Now under medical care or taking medication? No Yes

- Has there been any surgery, injury, illness, allergy, or change in health status since the last complete physical examination? No Yes

Is There Past or Present History of (give dates and full details for any "yes"):

	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"/>	_____	

IV. PARENTAL STATEMENTS & SIGNATURE

A. Has it ever been necessary to restrict applicant's activities for medical reasons? No Yes

B. Does applicant take regular medicine or require special care? No Yes (if yes, explain)

C. To the best of my knowledge all information in sections I, II, III, IV, and V is accurate and complete. I request the physician to examine applicant, to give immunization, and to furnish requested information to other agencies as needed. I give my permission for full participation in BSA programs subject to these limitations:

D. In the event of illness or accident in the course of such activity, I request that measures be instituted without delay as judgment of medical personnel dictates.

E. I give my permission for the following individuals to pick-up/transport my Scout from camp.

Parent or Guardian's Information:

Mother: _____
Address-home: _____
Address-work: _____
Phone-home: _____ work: _____

Father: _____
Address-home: _____
Address-work: _____
Phone-home: _____ work: _____

Parent or Guardian's Signature (must sign if applicant is under 18)

Applicant's Signature

Date Signed: _____

V. REQUIRED IMMUNIZATIONS: (last year given)

Tetanus: _____

Diphtheria: _____

Polio: _____

	Has Had	Vaccination	Disease
Measles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rubella	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pertussis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	No	Yes	Year	Details
Kidney, 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"/>	_____	
Diet restrictions (explain)	<input type="checkbox"/>	<input type="checkbox"/>	_____	

Explain: _____

NOTE: Keep original form for your personal record. Make reproductions for agency use. Be sure information and signatures are legible on reproduced copies. The upper section may be reproduced and carried with you for emergency identification.

Name: _____ Date: _____ Unit#: _____

MEDICAL EXAMINATION

REQUIRED ANNUALLY FOR ALL PARTICIPANTS IN CAMP FOR 72 HOURS OR MORE *

(* State of Colorado Children's Camp Regulations, Program Area VII, 7.7 11.41C)

VI. 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 (section V) before medical examination.
- 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 VI, summarize any restrictions and/or recommendations in sections III and VII and sign.

	VISION	HEARING
Date _____	Normal _____	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)		

IX. PHYSICIAN'S EVALUATION AND ADVISE:

Approved for participation in:

<input type="checkbox"/> Hiking and Camping	<input type="checkbox"/> Water Activities
<input type="checkbox"/> Competitive Sports	<input type="checkbox"/> All activities

Specify Exceptions/Restrictions: _____

X. AUTHORIZATION FOR ADMINISTRATION OF MEDICATION:

The BSA Health Supervisor is authorized to administer the following medication to the camper. All medicine must be in original container and labeled with name, Unit number and campsite.

Medication and dosage: _____

Medication and dosage: _____

Medication and dosage: _____

Medication and dosage: _____

Medication and dosage: _____

Medication and dosage: _____

VII. PHYSICIAN'S SIGNATURE: (certifying sections VI, IX & X)

Signed: _____

Date: _____

In addition to examination conducted by medical doctors of osteopathy, examinations by registered nurse practitioners will be recognized.

VIII. PHYSICIAN'S INFORMATION:

Personal Physician: _____

Address: _____

City/State/Zip: _____

24-hour Phone: _____

*** ADULT LEADERS MUST COMPLETE SECTION BELOW ***

Colorado Department of Human Services, *Minimum Rules and Regulations for Children's Camps*
General Requirements For All Personnel 7.711.21D & General Rules 7.701.53A

XI. UNDERSTANDING OF CHILD ABUSE:

Child Abuse consists of a wide variety of different problems. Usually these are categorized as *physical abuse, emotional abuse, sexual abuse, and neglect*. Physical abuse is the injury of the child by other than accidental means. Emotional abuse is the constant belittling, criticizing, yelling at, and verbal tearing down of the child. Sexual abuse is any sexual activity between a child and an adult, or sexual activity involving children in which the age, size, or other power factors between the participants is unequal. Child neglect is failure to provide necessary nurturance when resources are available to do so. My signature below signifies that I understand what child abuse is and that I am to report to the Camp Director any know or suspected instances of child abuse while at summer camp.

Signature: _____ Date: _____

XII. CHARACTER REFERENCE:

This section to be completed by an individual who knows the adult leader, and who can provide a frank evaluation of the adult's suitability in working with children in a week-long camp.

CIRCLE THE WORD THAT BEST DESCRIBES THE ADULT LEADER

ATTITUDE:	Enthusiastic	Positive	Acceptable	Negative
COMMON SENSE:	Always Sound	Usually Sound	Needs Direction	None
INTEGRITY:	Trustworthy	Usually Reliable	Lacking	

WOULD YOU TRUST THE CARE OF YOUR CHILD WITH THIS PERSON? YES NO

I RECOMMEND THIS PERSON AS AN ADULT LEADER. YES NO

Signature: _____ Date: _____

Printed Name: _____ Telephone: _____