DAY CAMP ADVENTURE AT DEER LAKE
Annual Health and Medical Record
(Valid for 12 calendar months)

Part A
GENERAL INFORMATION:

Name ____
Date of birth ____________________ Age ___________ Male / Female
Grade Entering __________________
Address: ____
City _____________________State ____________ Zip ______________

Who does this child reside with? ____

Parent/Guardian Name: ____
Phone _______________________________Cell Phone _________________________________

Parent/Guardian Name: ____
Phone _______________________________Cell Phone _________________________________

Health/Accident Insurance Company ____
Policy No. ____
ATTACH A PHOTOCOPY OF BOTH SIDES OF INSURANCE CARD. IF FAMILY HAS NO MEDICAL INSURANCE, STATE "NONE."

In case of emergency, notify: (if parent/guardian is unavailable)
Name ____
Relationship ____
Address ____
Home phone ________________________________
Business phone _____________________________
Cell phone _________________________________

Alternate contacts:
Name ____
Relationship ____
Home phone ________________________________
Business phone _____________________________
Cell phone _________________________________

Name ____
Relationship ____
Home phone ________________________________
Business phone _____________________________
Cell phone _________________________________

MEDICAL HISTORY:

Allergies or Reactions: (please include type of reaction and treatment):

Medication: ____
____
____

Food(s): ____
____
____

Insects/Plants: ____
____
____

<u>Are you/or have you been treated for any of the following?</u> Check all that apply

1. _______Asthma
2. _______High Blood Pressure
3. _______Stroke/TIA
4. _______Ear/sinus problems
5. _______Menstrual problems
6. _______Emotional difficulties
7. _______Bleeding disorders
8. _______Thyroid disease
9. _______Sickle cell disease
10. ______Sleep disorders
11. ______Surgery
12. ______Allergies
13. _______Diabetes
14. _______Heart disease
15. _______COPD
16. _______Muscular/skeletal condition
17. _______Psychiatric/psychological difficulties
18. _______Learning disorders (ADHD, ADD)
19. _______Fainting spells
20. _______Kidney disease
21. _______Seizures
22. _______GI problems abdominal, digestive)
23. _______Serious injury
24. _______Other

Please explain any checked conditions: (please reference above #)

____
____
____
____
____
____
____
____
____

Do you have:	**Yes**	**No**
Braces:	______	______
Orthodontic appliance:	______	______
Dentures/Bridges:	______	______
Contacts:	______	______

MEDICATIONS:

List **all** medications currently used. *No medication can be administered or kept at camp unless all sections are completed and signed by a Medical Professional and Parent!* *(This includes over the counter fever/pain reducers and topical applications.)*
(If additional space is needed, please print multiple copies of this page of the health form.)
Inhaler and EpiPen information must be included, even if they are for occasional or emergency use only.

NOTE: Be sure to bring medications to camp in original containers and make sure that they are NOT expired (including inhalers and EpiPens)
THIS MUST BE DONE PRIOR TO THE FIRST DAY OF THE CAMP SESSION!
You SHOULD NOT STOP taking any maintenance medication.

Medication: ______________________________
Strength ______________ Dosage ______________
Frequency ______________ Approximate date started ______________
Reason for medication ______________________________

Distribution approved by: ______________________________
MD/DO, NP, or PA Signature
Dates Authorized From: ______________ To: ______________

Parent Signature: ______________________________

Medication: ______________________________
Strength ______________ Dosage ______________
Frequency ______________ Approximate date started ______________
Reason for medication ______________________________

Distribution approved by: ______________________________
MD/DO, NP, or PA Signature
Dates Authorized From: ______________ To: ______________

Parent Signature: ______________________________

Medication: ______________________________
Strength ______________ Dosage ______________
Frequency ______________ Approximate date started ______________
Reason for medication ______________________________

Distribution approved by: ______________________________
MD/DO, NP, or PA Signature
Dates Authorized From: ______________ To: ______________

Parent Signature: ______________________________

Part B
PHYSICAL EXAMINATION (to be completed by a health-care professional)

Height_____________ Weight____________
Blood pressure____________ Pulse_____________

Immunization History: (Please fill in or attach a copy that includes dates)
Tetanus immunization must have been received within the last 10 years.
If had disease, write "D" and year.

Yes	No		Date
____	_____	Tetanus	______________________________
____	_____	Pertussis	______________________________
____	_____	Diphtheria	______________________________
____	_____	Measles	______________________________
____	_____	Mumps	______________________________
____	_____	Rubella	______________________________
____	_____	Polio	______________________________
____	_____	Chicken pox	______________________________
____	_____	Hepatitis A	______________________________
____	_____	Hepatitis B	______________________________
____	_____	Influenza	______________________________
____	_____	Other (HIB)	______________________________

SYSTEMS:

	Normal	Abnormal		Normal	Abnormal
Eyes	_______	______	Knees (both)	______	_______
Ears	_______	______	Ankles (both)	______	_______
Nose	_______	______	Spine	______	_______
Throat	_______	______	Inguinal hernia	______	_______
Lungs	_______	______	Emotional Adjustment	______	_______
Skin	_______	______	Genitalia	______	_______
Heart	_______	______	Abdomen	______	_______

Please explain any abnormalities or special considerations: ______________________________________
____
____
____
____

Allergies (to what agent; type of reaction, treatment) ____
____
____
____
____

I certify that I have, today, reviewed the health and immunization history, examined this person, and approve this individual for participation in: Hiking, Camping, Boating, Backpacking, Swimming/water activities, Climbing/rappelling, Sports, Ropes course
With Restrictions:(please explain) ____

____

Without Restrictions ____________

To Health Care Provider: Restricted approval includes:

- Uncontrolled heart disease, asthma, or hypertension.
- Uncontrolled psychiatric disorders.
- Poorly controlled diabetes.
- Orthopedic injuries not cleared by a physician.
- Newly diagnosed seizure events (within 6 months).

Certified and licensed health-care providers recognized by the BSA to perform this exam include physicians (MD, DO), nurse practitioners, and physician's assistants.

Provider printed name ____
Signature ____
Address ____
Office phone __________________________ Date ____________________

Part C

Informed Consent and Hold Harmless/Release Agreement

I understand that participation in Camp activities involves a certain degree of risk. I have carefully considered the risk involved and have given consent for myself and/or my child to participate in these activities. I understand that participation in these activities is entirely voluntary and requires participants to abide by applicable rules and standards of conduct. I release the Boy Scouts of America, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with the activity from any and all claims or liability arising out of this participation. I approve the sharing of the information on this form with BSA and Deer Lake Camp volunteers and professionals who need to know of medical situations that might require special consideration for the safe conducting of camp activities. In case of an emergency involving me or my child, I understand that every effort will be made to contact the individual listed as the emergency contact person. In the event that this person cannot be reached, permission is hereby given to the medical provider selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for me or my child. Medical providers are authorized to disclose to the adult in charge Protected Health Information/Confidential Health Information (PHI/CHI) under the Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. §§160.103, 164.501, etc. seq., as amended from time to time, including examination findings, test results, and treatment provided for purposes of medical evaluation of the participant, follow-up and communication with the participant's parents or guardian, and/or determination of the participant's ability to continue in the program activities.

Without restrictions. ______________________________
With special considerations or restrictions (list): ____

____

I understand that, if any information I/we have provided is found to be inaccurate, it may limit and/or eliminate the opportunity for participation in any event or activity.

Participant's name ____
Participant's signature ____
Parent/guardian's signature ____
(if under the age of 18)
Date ____