

NAME: \_\_\_\_\_ UNIT: \_\_\_\_\_

Bucks County Council, Boy Scouts of America  
One Scout Way, Doylestown PA 18901

**PERSONAL HEALTH AND MEDICAL RECORD FORM—Class 3**

**I. IDENTIFICATION** AGE \_\_\_\_ SEX \_\_\_\_

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY & STATE \_\_\_\_\_

ZIP \_\_\_\_\_

HEALTH/ACCIDENT INSURANCE \_\_\_\_\_ POLICY NO. \_\_\_\_\_

**IN AN EMERGENCY NOTIFY:**

Name \_\_\_\_\_ relationship \_\_\_\_\_

Address \_\_\_\_\_ (H) phone \_\_\_\_\_

City & State \_\_\_\_\_ (W) phone \_\_\_\_\_

**BOY SCOUTS OF AMERICA**

All Class 3 activities require a health examination within the past 12 months by a licensed health-care practitioner.\* This includes youth and adult members participating in high-adventure activities, athletic competitions, and world jamborees. Annually, this form is to be used by adults over 40 for all activities requiring a physical examination and applies to all Wood Badge participants/staff regardless of age.

**II. EMERGENCY MEDICAL INFORMATION:**

Allergy to a medicine, food, plant, animal, or insect toxin.

Any condition that may require special care, medication, or diet.

ADHD (Attention Deficit Hyperactive Disorder)

Asthma  Convulsions  Heart trouble  Contact lenses

Diabetes  Fainting spells  Bleeding disorders  Dentures

EXPLAIN \_\_\_\_\_

**III. PARENTAL STATEMENT:**

Has it ever been necessary to restrict applicant's activities for medical reasons?  No  Yes Does applicant take medicine regularly or have special care?  No  Yes

If yes, explain below.

To the best of my knowledge, the information in sections I, II, III, IV and V, is accurate and complete. I request a licensed health-care practitioner to examine applicant, to give needed immunizations, and to furnish requested information to other agencies as needed. I give my permission for full participation in BSA programs, subject to limitations noted herein. In the event of illness or accident in the course of such activity, I request that measures be instituted without delay as judgement of medical personnel dictates.

PARENT OR GUARDIAN \_\_\_\_\_ (Must sign if applicant is 18 or younger)

APPLICANT'S SIGNATURE \_\_\_\_\_

Date signed \_\_\_\_\_

**IV. IMMUNIZATIONS:**

If disease, put "D" and year.

Last Year Given

Tetanus \_\_\_\_\_

Diphtheria \_\_\_\_\_

Partussis \_\_\_\_\_

Measles \_\_\_\_\_

Rubella \_\_\_\_\_

Polio \_\_\_\_\_

Chicken Pox \_\_\_\_\_

Religious preference \_\_\_\_\_

**V. LICENSED HEALTH-CARE PRACTITIONER'S EVALUATION AND ADVICE:**

APPROVED FOR PARTICIPATION IN:

Hiking and camping  Competitive sports

Water activities  All activities

Specify exceptions \_\_\_\_\_

RECOMMENDATIONS: (Explain any restrictions OR limitations) \_\_\_\_\_

Date \_\_\_\_\_

SIGNED \_\_\_\_\_ \*Licensed health-care practitioner

\*Examinations conducted by licensed health-care practitioners other than physicians will be recognized for BSA purposes in those states where such practitioners may perform physical examinations within their legally prescribed scope of practice.

**VI. MEDICAL HISTORY**

Parent (or applicant if 18 or older): Fill in sections I, II, III, IV, and VI before seeing a licensed health-care practitioner. 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 of applicant since last complete examination.

- Date of most recent complete physical examination (month and year) \_\_\_\_\_
- Are you aware of any current health problems?  No  Yes
- Now under medical care or taking medicines?  No  Yes
- Has there been any surgery, injury, illness, allergy, or change in health status since last complete physical examination? No Yes

Give dates and full details below for any "yes" answers.

IS THERE DISEASE OF (OR PAST OR PRESENT HISTORY OF):

	No	Yes	Year	Details
Serious illness	___	___	___	___
Serious injury	___	___	___	___
Deformity	___	___	___	___
Surgery	___	___	___	___
Skin, glands	___	___	___	___
Ears, eyes	___	___	___	___
Nose, sinus	___	___	___	___
Teeth, tonsils	___	___	___	___
Dentures	___	___	___	___
Bridge	___	___	___	___
Chest, lungs	___	___	___	___
Heart	___	___	___	___
Murmur	___	___	___	___
Rheumatic fever	___	___	___	___
Stomach, bowels	___	___	___	___
Appendicitis	___	___	___	___
Kidneys or urine	___	___	___	___
Albumin	___	___	___	___
Sugar	___	___	___	___
Infection	___	___	___	___
Bed-wetting	___	___	___	___
Menstrual problems	___	___	___	___
Hernia (rupture)	___	___	___	___
Back, limbs, joints	___	___	___	___
Sleepwalking	___	___	___	___
Nervous condition	___	___	___	___
Other (explain)	___	___	___	___

**VII. HEALTH EXAMINATION**

Licensed Health-Care Practitioner:

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 that applicant furnish complete medical history (VI) before exam.
- Review immunizations; for youth (18 or younger) tetanus and diphtheria toxoids, measles, mumps, and rubella vaccines, and trivalent oral polio vaccine are required; youths and adults must have had tetanus booster within 10 years. A measles booster is recommended at age 12.
- After completing section VII, summarize any restrictions and/or recommendations in sections II and V above and sign.

Date \_\_\_\_\_ VISION \_\_\_\_\_ HEARING \_\_\_\_\_

Ht. \_\_\_\_\_ Wt. \_\_\_\_\_ Normal \_\_\_\_\_ Abnormal \_\_\_\_\_

B.P. \_\_\_\_\_ / \_\_\_\_\_ Pulse \_\_\_\_\_ Glasses \_\_\_\_\_ Contacts \_\_\_\_\_

Check line if normal: circle if abnormal and give details below:

\_\_\_ Growth, development \_\_\_ Teeth, tonsils \_\_\_ Genitourinary

\_\_\_ Skin, glands, hair \_\_\_ Respiratory \_\_\_ Skeletomascular

\_\_\_ Head, neck, thyroid \_\_\_ Cardiovascular \_\_\_ Neuropsychiatric

\_\_\_ Eyes, ears, nose \_\_\_ Abdomen, hernia, rings \_\_\_ Other (specify)

COMMENTS \_\_\_\_\_

**REVIEW FOR CAMP OR SPECIAL ACTIVITY**

DATE	AGENCY AND ACTIVITY	BY	"OK"	PHYSICIAN RECHECK NEEDED	RESULTS OF RECHECK	INITIAL

**INTERNAL RECORDS**

(CAMP, CAMPOREE, TOURNAMENT, TRAVEL, ETC.)

DATE, TIME, PLACE, ETC.	FINDING, DIAGNOSES, TREATMENT, INSTRUCTIONS, DISPOSITIONS, ETC.	BY: