



HOW TO FILL OUT THE NEW BSA HEALTH FORM

BACKGROUND

- ✘ Until last year, every Council within the Boy Scouts of America had a different Health Form. Last year, because of the National Jamboree, the BSA decided to come up with one form for all Scouts to use, so that when they were reviewed by BSA personnel they would be reviewing just one format instead of a hundred or more different formats. The new form and the policy regarding it's usage, standardizes how often Scouts must get a Physical and what information must be submitted for what kind of activity. All this information is printed on the instruction page which is the first or Title Page of the Form.
- ✘ All Scouts must now have a Health Form on File. Most Scouts only require Parts A and B to be filled out and turned in. Summer Camp, Treks and High Adventure Activities also require Part C, which is the Medical Evaluation performed by a Doctor.

Annual Health and Medical Record

(Valid for 12 calendar months)

Policy on Use of the Annual Health and Medical Record

In order to provide better care for its members and to assist them in better understanding their own physical capabilities, the Boy Scouts of America recommends that everyone who participates in a Scouting event have an annual medical evaluation by a certified and licensed health-care provider—a physician (MD or DO), nurse practitioner, or physician assistant. Providing your medical information on this four-part form will help ensure you meet the minimum standards for participation in various activities. Note that unit leaders must always protect the privacy of unit participants by protecting their medical information.

Parts A and B are to be completed at least annually by participants in all Scouting events. This health history, parental/guardian informed consent and hold harmless/release agreement, and talent release statement is to be completed by the participant and parents/guardians.

Part C is the physical exam that is required for participants in any event that exceeds 72 consecutive hours, for all high-adventure base participants, or when the nature of the activity is strenuous and demanding. Service projects or work weekends may fit this description. Part C is to be completed and signed by a certified and licensed health-care provider—physician (MD or DO), nurse practitioner, or physician assistant. It is important to note that the height/weight limits must be strictly adhered to when the event will take the unit more than 30 minutes away from an emergency vehicle-accessible roadway, or when the program requires it, such as backpacking trips, high-adventure activities, and conservation projects in remote areas. See the FAQs for when this does not apply.

Part D is required to be reviewed by all participants of a high-adventure program at one of the national high-adventure bases and shared with the examining health-care provider before completing Part C.

- **Philmont Scout Ranch.** Participants and guests for Philmont activities that are conducted with limited access to the backcountry, including most Philmont Training Center conferences and family programs, will not require completion of Part C. However, participants should review Part D to understand potential risks inherent at 6,700 feet in elevation in a dry Southwest environment. Please review specific registration information for the activity or event.
- **Northern Tier National High Adventure Base.**
- **Florida National High Adventure Sea Base.** The PADI medical form is also required if scuba diving at this base.

Risk Factors

Based on the vast experience of the medical community, the BSA has identified the following risk factors that may limit your participation in various outdoor adventures.

- Excessive body weight
- Heart disease
- Hypertension (high blood pressure)
- Diabetes
- Seizures
- Lack of appropriate immunizations
- Asthma
- Allergies/anaphylaxis
- Muscular/skeletal injuries
- Psychiatric/psychological and emotional difficulties

For more information on medical risk factors, visit Scouting Safely on www.scouting.org.

Prescriptions

The taking of prescription medication is the responsibility of the individual taking the medication and/or that individual's parent or guardian. A leader, after obtaining all the necessary information, can agree to accept the responsibility of making sure a youth takes the necessary medication at the appropriate time, but BSA does not mandate or necessarily encourage the leader to do so. Also, if state laws are more limiting, they must be followed.

Frequently Asked Questions (FAQs)

- Philmont Scout Ranch: www.philmontscoutranch.org or 575-376-2281
- Northern Tier National High Adventure Base: www.ntier.org or 218-365-4811
- Florida National High Adventure Sea Base: www.bsaseabase.org or 305-664-5612
- National Scout Jamboree: www.bsajamboree.org

For frequently asked questions about this Annual Health and Medical Record, see Scouting Safely online at <http://www.scouting.org/scoutsource/HealthandSafety.aspx>. Information about the Health Insurance Portability and Accountability Act (HIPAA) may be found at <http://www.hipaa.org>.



BOY SCOUTS OF AMERICA®

You can see from the Instruction Page, that for Summer Camp and for the Jamboree, that all three Parts (A,B, and C of the Form must be filled out. It states that it is to be completed and signed by a certified and licensed health-care provider-physician (MD, DO), nurse practitioner, or physician's assistant as appropriate for you state.

However, your son's Doctor, will probably not fill this form out for you. You will need to fill in most of the information on the form, then bring it to the Doctor for the Physical. The Doctor should then fill out the blocks on the form that pertain his physical exam of your Scout. (click for next slide).

Emergency contact No.:
Allergies:
DOB:
Full name:

**Annual BSA Health and Medical Record
Part A**

GENERAL INFORMATION

High-adventure base participants:
Expedition/crew No.: _____
or staff position: _____

Name _____ Date of birth _____ Age _____ Male Female
Address _____ Grade completed (youth only) _____
City _____ State _____ Zip _____ Phone No. _____
Unit leader _____ Council name/No. _____ Unit No. _____
Social Security No. (optional; may be required by medical facilities for treatment) _____ Religious preference _____
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:
Name _____ Relationship _____
Address _____
Home phone _____ Business phone _____ Cell phone _____
Alternate contact _____ Alternate's phone _____

HEALTH HISTORY

Are you now, or have you ever been treated for any of the following:

Yes	No	Condition	Explain
		Asthma Last attack: _____	
		Diabetes Last HbA1c: _____	
		Hypertension (high blood pressure)	
		Heart disease (e.g., CHF, CAD, MI)	
		Stroke/TIA	
		Lung/respiratory disease	
		Ear/sinus problems	
		Muscular/skeletal condition	
		Menstrual problems (women only)	
		Psychiatric/psychological and emotional difficulties	
		Behavioral disorders (e.g., ADD, ADHD, Asperger syndrome, autism)	
		Bleeding disorders	
		Fainting spells	
		Thyroid disease	
		Kidney disease	
		Sickle cell disease	
		Seizures Last seizure: _____	
		Sleep disorders (e.g., sleep apnea) Use CPAP: Yes <input type="checkbox"/> No <input type="checkbox"/>	
		Abdominal/digestive problems	
		Surgery	
		Serious injury	
		Other	

Allergies or Reaction to:
Medication _____
Food, Plants, or Insect Bites _____

Immunizations:
The following are recommended by the BSA. **Tetanus immunization is required and must have been received within the last 10 years.** If had disease, put "D" and the year. If immunized, check the box and the year received.

Yes	No	Date
<input type="checkbox"/>	<input type="checkbox"/>	Tetanus _____
<input type="checkbox"/>	<input type="checkbox"/>	Pertussis _____
<input type="checkbox"/>	<input type="checkbox"/>	Diphtheria _____
<input type="checkbox"/>	<input type="checkbox"/>	Measles _____
<input type="checkbox"/>	<input type="checkbox"/>	Mumps _____
<input type="checkbox"/>	<input type="checkbox"/>	Rubella _____
<input type="checkbox"/>	<input type="checkbox"/>	Polio _____
<input type="checkbox"/>	<input type="checkbox"/>	Chicken pox _____
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A _____
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B _____
<input type="checkbox"/>	<input type="checkbox"/>	Influenza _____
<input type="checkbox"/>	<input type="checkbox"/>	Other (i.e., Hib) _____

Exemption to immunizations claimed (form required).

(For more information about immunizations, as well as the immunization exemption form, see **Scouting Safely on Scouting.org.**)

MEDICATIONS

List all medications currently used. (If additional space is needed, please photocopy this part of the health form.) Inhalers and EpiPen information must be included, even if they are for occasional or emergency use only.

Medication _____ Strength _____ Frequency _____ Approximate date started _____ Reason for medication _____	Medication _____ Strength _____ Frequency _____ Approximate date started _____ Reason for medication _____	Medication _____ Strength _____ Frequency _____ Approximate date started _____ Reason for medication _____
Medication _____ Strength _____ Frequency _____ Approximate date started _____ Reason for medication _____	Medication _____ Strength _____ Frequency _____ Approximate date started _____ Reason for medication _____	Medication _____ Strength _____ Frequency _____ Approximate date started _____ Reason for medication _____

Administration of the above medications is approved by (if required by your state): _____
Parent/guardian signature and/or MD/DO, NP, or PA signature

Be sure to bring medications in sufficient quantities and the original containers. Make sure that they are NOT expired, including inhalers and EpiPens. You SHOULD NOT STOP taking any maintenance medication.

You may download the Health Form from our Troop website. Here is the Url.

<http://t205.net/SummerCamp/summercampbuttons/wakmed1.jpg>

The new Health Form is in .pdf format. When you open it you will notice most of the fields are highlighted in light blue. You may type the information required right from your Computer. (click for next slide)

Please attach a copy of both sides of your Health Insurance Card.

Annual BSA Health and Medical Record Part A

GENERAL INFORMATION

High-adventure base participants:

Expedition/crew No.: _____
or staff position: _____

Name _____ Date of birth _____ Age _____ Male Female
Address _____ Grade completed (youth only) _____
City _____ State _____ Zip _____ Phone No. _____
Unit leader _____ Council name/No. _____ Unit No. _____
Social Security No. (optional; may be required by medical facilities for treatment) _____ Religious preference _____
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:

Name _____ Relationship _____
Address _____
Home phone _____ Business phone _____ Cell phone _____
Alternate contact _____ Alternate's phone _____

Emergency contact No.:

The General Information block is self explanatory. As you type the information into the form it will automatically fill in the information that is required and displayed vertically along the left margin. Please fill in all the information. Your Unit Leader is Mr. Businski, and the Council name/No. is Suffolk County Council/ 404. (Click for next slide)

Please attach a photo copy of both sides of your Health Insurance Card!

Emergencies: _____
 Allergies: _____
 OB: _____

HEALTH HISTORY

Are you now, or have you ever been treated for any of the following:

Yes	No	Condition	Explain
		Asthma Last attack: _____	
		Diabetes Last HbA1c: _____	
		Hypertension (high blood pressure)	
		Heart disease (e.g., CHF, CAD, MI)	
		Stroke/TIA	
		Lung/respiratory disease	
		Ear/sinus problems	
		Muscular/skeletal condition	
		Menstrual problems (women only)	
		Psychiatric/psychological and emotional difficulties	
		Behavioral disorders (e.g., ADD, ADHD, Asperger syndrome, autism)	
		Bleeding disorders	
		Fainting spells	
		Thyroid disease	
		Kidney disease	
		Sickle cell disease	
		Seizures Last seizure: _____	
		Sleep disorders (e.g., sleep apnea)	Use CPAP: Yes <input type="checkbox"/> No <input type="checkbox"/>
		Abdominal/digestive problems	
		Surgery	
		Serious injury	
		Other	

Allergies or Reaction to:

Medication _____
 Food, Plants, or Insect Bites _____

Immunizations:

The following are recommended by the BSA. **Tetanus immunization is required and must have been received within the last 10 years.** If had disease, put "D" and the year. If immunized, check the box and the year received.

Yes	No	Date
<input type="checkbox"/>	<input type="checkbox"/>	Tetanus _____
<input type="checkbox"/>	<input type="checkbox"/>	Pertussis _____
<input type="checkbox"/>	<input type="checkbox"/>	Diphtheria _____
<input type="checkbox"/>	<input type="checkbox"/>	Measles _____
<input type="checkbox"/>	<input type="checkbox"/>	Mumps _____
<input type="checkbox"/>	<input type="checkbox"/>	Rubella _____
<input type="checkbox"/>	<input type="checkbox"/>	Polio _____
<input type="checkbox"/>	<input type="checkbox"/>	Chicken pox _____
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A _____
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B _____
<input type="checkbox"/>	<input type="checkbox"/>	Influenza _____
<input type="checkbox"/>	<input type="checkbox"/>	Other (i.e., HIB) _____

Exemption to immunizations claimed (form required).

The Medical History Block is to be filled out by you and is self explanatory. Simply click on the Yes or No Box to note your selection. If you select yes for a condition, please fill out the **Explain** box. Fill in any allergies or reactions to Medication or Food, Plants or Insect Bites. Immunizations are covered in the next slide. (click)

Allergies or Reaction to:

Medication _____

Food, Plants, or Insect Bites _____

Immunizations:

The following are recommended by the BSA.

Tetanus immunization is required and must have been received within the last 10 years. If had disease, put "D" and the year. If immunized, check the box and the year received.

Yes	No	Date
<input type="checkbox"/>	<input type="checkbox"/>	Tetanus _____
<input type="checkbox"/>	<input type="checkbox"/>	Pertussis _____
<input type="checkbox"/>	<input type="checkbox"/>	Diphtheria _____
<input type="checkbox"/>	<input type="checkbox"/>	Measles _____
<input type="checkbox"/>	<input type="checkbox"/>	Mumps _____
<input type="checkbox"/>	<input type="checkbox"/>	Rubella _____
<input type="checkbox"/>	<input type="checkbox"/>	Polio _____
<input type="checkbox"/>	<input type="checkbox"/>	Chicken pox _____
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A _____
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B _____
<input type="checkbox"/>	<input type="checkbox"/>	Influenza _____
<input type="checkbox"/>	<input type="checkbox"/>	Other (i.e., HIB) _____

Exemption to immunizations claimed (form required).

(For more information about immunizations, as well as the immunization exemption form, see Scouting Safely on Scouting.org.)

Theoretically, your Health Provider should fill in the Immunizations Block. However, after reviewing Health Forms for the past few years, I have found out that most will simply give you a photo copy of your Scouts Immunizations. Please fill in the yes or no blocks manually and indicate the **month and year** that the inoculation was given. **The month and year is required by New York State Law.** If you have a copy of the immunizations before you take the form to the Doctor, you may type them in. Most of the Vaccines will have abbreviations. For a list of these abbreviations see next slide. I have highlighted the most common. (click for next slide)



Vaccines and Immunizations

Glossary / Acronyms:

Vaccine Acronyms & Abbreviations

This vaccine abbreviations page lists abbreviations used for vaccines, including some "old" or non-standard abbreviations used on immunization records.

See also: "[Translating Foreign Immunization Records](#)"  (.pdf - 2 pages) (exit)

ADPTIN
 Adult Tdap (Kaiser Permanente)
 AVA
 Anthrax Vaccine Adsorbed
 BCG
 Bacille Calmette-Guérin (Tuberculosis) Vaccine
 DPT
 Replaced by use of DTP. See *DTP* for description.
 DT
 Diphtheria and tetanus toxoids, pediatric formulation
 DTaP
 Diphtheria and tetanus toxoids and acellular pertussis vaccine, pediatric formulation
 DTP
 Diphtheria and tetanus toxoids and whole-cell pertussis vaccine, pediatric formulation
 eIPV
 Enhanced inactivated polio vaccine
 HAV
 Hepatitis A Virus
 HbOC
 Haemophilus b Oligosaccharide Conjugate (Hib) Vaccine*
 HBV
 Hepatitis B Virus
 Hib
Haemophilus influenzae type b
 HPV
 Human Papillomavirus
 IHBDTP
 Pediarix (Kaiser Permanente)
 IPV
 Inactivated Poliovirus Vaccine
 JE
 Japanese Encephalitis
 LAIV
 Live, Attenuated Influenza Vaccine (Nasal Spray)



MCV
 Measles-containing vaccines
 MCV4
 Meningococcal Conjugate Vaccine (Quadravalent)
 MMR
 Measles, Mumps & Rubella Vaccine
 MMRV
 Measles, Mumps, Rubella & Varicella Vaccine
 MPSV4
 Meningococcal Polysaccharide Vaccine (Quadravalent)
 MR
 Measles-rubella Vaccine
 OPV
 Oral Polio Vaccine*
 PCV7 (or PCV)
 Pneumococcal Conjugate Vaccine (7-valent) (*replaced the old acronym PCV*)
 PNCV7
 Pneumococcal Conjugate Vaccine (7-valent) (Kaiser Permanente)
 PPV23 (or PPV)
 Pneumococcal Polysaccharide Vaccine (23-valent) (*PPV23 and PPV are old acronyms as of 2008; the new acronym is PPSV-23*)
 PPSV23
 Pneumococcal Polysaccharide Vaccine (23-valent) (*replaced the old acronyms PPV and PPV23*)
 PRP
 Polyribosylribitol Phosphate Polysaccharide (Hib) Vaccine*
 PRP-D
 Polyribosylribitol Phosphate-Diphtheria Conjugate (Hib) Vaccine*
 PRP-OMP
 Polyribosylribitol Phosphate-Outer Membrane Protein Conjugate (Hib) Vaccine
 PRP-T
 Polyribosylribitol Phosphate-Tetanus Conjugate (Hib) Vaccine
 PRV
 Pentavalent Rotavirus Vaccine (i.e., RotaTeq®) supplanted by ROTA, then by RV1 and RV5
 ROTA
 Rotavirus Vaccine
 Td
 Tetanus & diphtheria Vaccine, adult/adolescent formulation
 Tdap
 Tetanus, diphtheria & acellular pertussis vaccine, adult/adolescent formulation
 TIV
 Trivalent (Inactivated) Influenza Vaccine
 TT
 Tetanus Toxoid
 Ty21a
 Live Oral Typhoid Vaccine
 VAR
 Varicella Vaccine (*CHICKEN POX*)
 ViCPS
 Vi Capsular Polysaccharide (Inactivated Typhoid) Vaccine

DC
Full name: _____

MEDICATIONS

List all medications currently used. (If additional space is needed, please photocopy this part of the health form.) Inhalers and EpiPen information must be included, even if they are for occasional or emergency use only.

(For more information about immunizations, as well as the immunization exemption form, see Scouting Safely on Scouting.org.)

Medication _____ Strength _____ Frequency _____ Approximate date started _____ Reason for medication _____ _____	Medication _____ Strength _____ Frequency _____ Approximate date started _____ Reason for medication _____ _____	Medication _____ Strength _____ Frequency _____ Approximate date started _____ Reason for medication _____ _____
Medication _____ Strength _____ Frequency _____ Approximate date started _____ Reason for medication _____ _____	Medication _____ Strength _____ Frequency _____ Approximate date started _____ Reason for medication _____ _____	Medication _____ Strength _____ Frequency _____ Approximate date started _____ Reason for medication _____ _____

Administration of the above medications is approved by (if required by your state): _____ / _____
Parent/guardian signature and/or MD/DO, NP, or PA signature

Be sure to bring medications in sufficient quantities and the original containers. Make sure that they are NOT expired, including inhalers and EpiPens. You SHOULD NOT STOP taking any maintenance medication.

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The Medications Block may be filled out by you or your Doctor. I recommend you fill out as much information as you can before you take the form to your Scouts Doctor. You must include all Prescription and Non Prescription (over the counter) medications your Scout is authorized to have, including Tylenol, Aspirin, Pepto Bismol, Claritin, etc. The Camps Medical office will not dispense any medication that is not specifically approved, by it's entry on this form, and with your signature and your Doctor's Signature, indicating his approval. (Click for next slide)

Part B

INFORMED CONSENT AND HOLD HARMLESS/RELEASE AGREEMENT

High-adventure base participants: Expedition/crew No.: _____ or staff position: _____
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I understand that participation in Scouting activities involves a certain degree of risk and can be physically, mentally, and emotionally demanding. I also understand that participation in these activities is entirely voluntary and requires participants to abide by applicable rules and standards of conduct.

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 protected health information to the adult in charge, camp medical staff, camp management, and/or any physician or health care provider involved in providing medical care to the participant. 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, includes 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.

I have carefully considered the risk involved and give consent for myself and/or my child to participate in these activities. I approve the sharing of the information on this form with BSA volunteers and professionals who need to know of medical situations that might require special consideration for the safe conducting of Scouting activities.

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.

- Without restrictions.
- With special considerations or restrictions (list) _____

TALENT RELEASE AGREEMENT

I hereby assign and grant to the local council and the Boy Scouts of America the right and permission to use and publish the photographs/ film/videotapes/electronic representations and/or sound recordings made of me or my child at all Scouting activities, and I hereby 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 liability from such use and publication.

I hereby authorize the reproduction, sale, copyright, exhibit, broadcast, electronic storage, and/or distribution of said photographs/ film/videotapes/electronic representations and/or sound recordings without limitation at the discretion of the Boy Scouts of America, and I specifically waive any right to any compensation I may have for any of the foregoing.

- Yes No

ADULTS AUTHORIZED TO TAKE YOUTH TO AND FROM EVENTS:

You must designate at least one adult. Please include a telephone number.

- 1. Name _____ Telephone _____
- 2. Name _____ Telephone _____
- 3. Name _____ Telephone _____

Adults NOT authorized to take youth to and from events:

- 1. Name _____
- 2. Name _____
- 3. Name _____

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.

If I am participating at Philmont, Philmont Training Center, Northern Tier, or Florida Sea Base: I have also read and understand the risk advisories explained in Part D, including height and weight requirements and restrictions, and understand that the participant will not be allowed to participate in applicable high-adventure programs if those requirements are not met. The participant has permission to engage in all high-adventure activities described, except as specifically noted by me or the health-care provider.

Participant's name _____

Participant's signature _____ Date _____

Parent/guardian's signature _____ Date _____
(if participant is under the age of 18)

Second parent/guardian signature _____ Date _____
(if required; for example, CA)

This Annual Health and Medical Record is valid for 12 calendar months.

Part B Full name: _____ **DOB:** _____

**Part B Consent/ Hold Harmless/
Release portion of the Form.
Please read the agreement.**

Normally, you as the Parent/ Guardian of your Scout, will drop him off at the Firehouse, or Timber Point Elementary, to start a Scouting Event. This Block gives you the opportunity to designate individuals who may drop off or pick your Scout up, should you not be able to do so. You may also designate individuals who may not pick him up.



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.

If I am participating at Philmont, Philmont Training Center, Northern Tier, or Florida Sea Base: I have also read and understand the risk advisories explained in Part D, *including height and weight requirements and restrictions*, and understand that the participant will not be allowed to participate in applicable high-adventure programs if those requirements are not met. The participant has permission to engage in all high-adventure activities described, except as specifically noted by me or the health-care provider.

Participant's name _____

Participant's signature _____ Date _____

Parent/guardian's signature _____ Date _____
(if participant is under the age of 18)

Second parent/guardian signature _____ Date _____
(if required; for example, CA)

This Annual Health and Medical Record is valid for 12 calendar months.

Part B Full name: _____ DOB: _____

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Please sign and date the form at the bottom. Your signature not only indicates the accuracy of the contents of the form, but is your permission for your Scout to Participate.

Please attach Photo copy of Health Insurance Card!

Examiner/crew no.: _____
 or staff position: _____

Part C

TO THE EXAMINING HEALTH-CARE PROVIDER (Certified and licensed physicians [MD, DO], nurse practitioners, and physician's assistants)

You are being asked to certify that this individual has no contraindication for participation in a Scouting experience. For individuals who will be attending a high-adventure program at one of the national high-adventure bases, please refer to Part D for additional information.

(Part D was made available to me. Yes No)

PHYSICAL EXAMINATION

Height (inches) _____ Weight (pounds) _____ Maximum weight for height _____ Meets height/weight limits Yes No
 Blood pressure _____ Pulse _____ Percent body fat (optional) _____

If you exceed the maximum weight for height as explained on this page and your planned high-adventure activity will take you more than 30 minutes away from an emergency vehicle-accessible roadway, you **will not** be allowed to participate. At the discretion of the medical advisors of the event and/or camp, participation of an individual exceeding the maximum weight for height may be allowed if the body fat percentage measured by the health-care provider is determined to be 20 percent or less for a female or 15 percent or less for a male. (Philmont requires a water-displacement test to be used for this determination.) Please call the event leader and/or camp if you have any questions. Enforcing the height/weight guidelines is strongly encouraged for all other events.

	Normal	Abnormal	Explain Any Abnormalities	Range of Mobility	Normal	Abnormal	Explain Any Abnormalities
Eyes				Knees (both)			
Ears				Ankles (both)			
Nose				Spine			
Throat							
Lungs							
Neurological				Other	Yes	No	
Heart				Contacts			
Abdomen				Dentures			
Genitalia				Braces			
Skin				Inguinal hernia			Explain
Emotional adjustment				Medical equipment (i.e., CPAP, oxygen)			
Tuberculosis (TB) skin test (if required by your state for BSA camp staff) <input type="checkbox"/> Negative <input type="checkbox"/> Positive							

Allergies (to what agent, type of reaction, treatment): _____

Restrictions (if none, so state) _____

EXAMINER'S CERTIFICATION

I certify that I have reviewed the health history and examined this person and find no contraindications for participation in a Scouting experience. This participant (with noted restrictions above)

True False

- Meets height/weight requirements
- Does not have uncontrolled heart disease, asthma, or hypertension
- Has not had an orthopedic injury, musculoskeletal problems, or orthopedic surgery in the last six months or possesses a letter of clearance from their orthopedic surgeon or treating physician
- Has no uncontrolled psychiatric disorders
- Has had no seizures in the last year
- Does not have poorly controlled diabetes
- If less than 18 years of age and planning to scuba dive, does not have diabetes, asthma, or seizures

Provider printed name _____
 Address _____
 City, state, zip _____
 Office phone _____
 Signature _____
 Date _____

Height (inches)	Recommended Weight (lbs)	Allowable Exception	Maximum Acceptance
60	97-138	139-166	166
61	101-143	144-172	172
62	104-148	149-178	178
63	107-152	153-183	183
64	111-157	158-189	189
65	114-162	163-195	195
66	118-167	168-201	201
67	121-172	173-207	207
68	125-178	179-214	214
69	128-185	186-220	220
70	132-188	189-226	226
71	136-194	195-233	233
72	140-199	200-239	239
73	144-205	206-246	246
74	148-210	211-252	252
75	152-216	217-260	260
76	156-222	223-267	267
77	160-228	229-274	274
78	164-234	235-281	281
79 & over	170-240	241-295	295

This table is based on the revised Dietary Guidelines for Americans from the U.S. Dept. of Agriculture and the Dept. of Health & Human Services.

REVIEW FOR CAMP OR SPECIAL ACTIVITY

Reviewed by _____ Date _____
 Further approval required Yes No Reason _____
 By _____ Date _____

DO NOT WRITE IN THIS BOX

Part C Full name: _____ **DOB:** _____

Part C is the Physical Examination Report portion of the Form. This is where your Scouts Doctor will record the results of the Physical Many Doctors will simply stamp his name and address on the form. This is OK, but please make sure he (she) provides the date of the examination on the date line, as well as his (her) phone number (incase a question arises). (click for next slide)

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- ✘ That is all there is to it, your Scout's Health Form is Complete. You may turn it into me or Assistant Scoutmaster Fitzmaurice at a Troop Meeting, or you can mail it to me at 25 Menasha Lane, E. Islip, NY 11730. If you have questions, please contact me at home (631-859-1085), my cell (631-839-3444) or Text my cell number, or e-mail me at jelliott@optonline.net . I need to have all Health Forms submitted to me by July 1st. Thank you in advance for your cooperation.
 - ✘ Yours in Scouting,
 - ✘ John Elliott
 - ✘ Asst. Scoutmaster