

**ADULT HEALTH HISTORY
(To Be Completed by Adult)**

IF YES IS CHECKED, PLEASE GIVE FULL DETAILS

* **HAVE OR SUBJECT TO:** (Check if YES)

IF NONE: Check here _____

_____ Heart Problems	_____ Asthma*****Uses an Inhaler	No _____	Yes _____
_____ Seizure/convulsion Disorder	_____ Diabetes*****Uses Insulin	No _____	Yes _____
_____ Kidney Disorder	_____ Behavioral/Emotional Concerns	_____	
_____ Medication Allergies:	List _____	_____	
_____ Food Allergies:	List _____	_____	
_____ Seasonal Allergies:	List _____	_____	
_____ Stinging Insect Reaction:	Treatment _____	_____	
_____ Fainting Spells	_____		
_____ Bleeding Disorder	_____		
_____ Other Health Concern(s):	_____		

***HAVE DIFFICULTY WITH:** (Check if YES)

IF NONE: Check here _____

_____ Tires easily	_____ Muscle Fatigue	_____ Ear Infections
_____ Breathing	_____ Nose Bleeding	_____ Sinus Infections
_____ Stomach/Bowels	_____ Sleeping	_____ Athletes Foot

Explain: _____

***CURRENT HEALTH STATUS:** (Check if YES)

IF NONE: Check here _____

_____ Currently under medical care.	{Explain: _____
_____ Currently taking any medications.	{Complete CURRENT MEDICATION SECTION
_____ Serious illness/injury in past year	Explain: _____
_____ Current behavioral/emotional concerns.	Explain: _____
_____ Other current health concerns.	Explain: _____

_____ Diet restrictions.	Explain: _____
_____ Activity restrictions.	Explain: _____
_____ Wears contacts.	_____ Wears bridge work or dentures

***IMMUNIZATION HISTORY**

(MUST indicate last inoculation date(s):

_____ Tetanus Booster	_____ Negative TB Test of Chest X-Ray (STAFF ONLY)
_____ Hepatitis B (optional)	_____ Haemophilus influenza B (optional)

The following immunizations are current and up to date:

- MMR (measles, mumps, rubella)
- DPT (diphtheria, pertussis, tetanus)
- Polio, Smallpox, Varicella (Chicken Pox), BCG
- And other _____

Special Diet needs or restrictions: _____

** Signature _____ Date _____

** Signature _____ Date _____

** Signature _____ Date _____

Current year signature required

CURRENT MEDICATIONS: (Prescriptions & Non-Prescriptions)

_____ I take NO medications on a routine basis

I take the following medications on a regular basis.

Med # 1 _____ Dosage _____ Times to be given _____

Med # 2 _____ Dosage _____ Times to be given _____

Med # 3 _____ Dosage _____ Times to be given _____

Med # 4 _____ Dosage _____ Times to be given _____

Med # 5 _____ Dosage _____ Times to be given _____

Attach additional pages for more medications.

TO BE COMPLETED BY A LICENSED MEDICAL PROVIDER

Note:

The Boy Scouts of America **requires** that adults (under 40) participating in any long-term camping experience (more than 72 hours):

- a. **MUST** have a medical evaluation by a licensed medical provider within **36 months** of the camping experience
- b. **MUST** have a health history completed within **12 months** of the camping experience.
- c. Adults 40 and over – must have medical evaluation and health history completed every **12 months**.

I certify that I have examined _____ on _____
Adults Name Date of Exam

And find him/her physically fit to participate in all Scouting activities EXCEPT as noted below. The aforementioned individual has all required immunizations as required by the State of Michigan.

Ht. _____ Wt. _____ B/P. _____ / _____ Pulse _____

Check box if NORMAL: Circle if ABNORMAL and give details below:

_____ GI	_____ Endocrine	_____ Genitourinary	_____ Skin, glands, hair
_____ Respiratory	_____ Skeletomuscular	_____ Head, Neck, thyroid	_____ Cardiovascular
_____ Neuropsychiatric	_____ Eyes, Ears, Nose	_____ Abdomen, Hernia	_____ Other (Specify)

Comments: _____

Restrictions/Limitations: _____

Provider Signature _____ Provider Name _____

Provider Phone Number () _____

The Michigan Department of Consumer and Industry Services pursuant to public Act 116 of 1973 and Administrative Rule 109.(4) REQUIRES the following information.

Registered position in council: _____ Position in Camp _____
 Number of years registered with the BSA: _____ years.
 Number of years/seasons in summer camp as an adult leader: _____ years.
 Number of years in Leadership of short term weekend camping: _____ years.

Please indicate training received and date issued:

BSA Training

Basic Leader Training _____
 Youth Protection _____
 Woodbadge _____
 Camp School _____
 Section _____

Health and Safety Training

CPR (Red Cross/American Heart) _____
 Basic First Aid (Red Cross) _____
 Other Medical Trng / License _____
 Describe _____

Water Safety Training

Safe Swim Defense _____
 Safety Afloat _____
 ARC Water Safety Inst. _____
 BSA Lifeguard _____
 Other _____
 Describe _____

Field Sports Training

National Rifle Association _____
 National Archery Association _____
 Hunter Safety Instructor _____

Other Outdoor Education Skills/Hobbies

Explain _____

Have you ever been convicted of anything other than minor traffic violations? _____ yes _____ no

If yes, please explain _____

My signature below verifies that I have knowledge and understanding of the requirements for reporting suspected cases of child abuse/neglect, as stated in the camp policy dealing with child abuse/neglect and that the information on this form is correct to the best of my knowledge.

**** Signature _____ Date _____**

REFERENCES FOR ADULT LEADERS (Must be completed prior to camp)

As a representative for the above-identified individual's unit, I recommend him/her to serve as an adult leader for BSA.

 Signature of registered adult from individual's unit Print Name Unit #

Knowing the good character of the above-identified individual, I recommend him/her to serve as an adult leader for BSA

 Character Reference Signature # 1 Print Name

Knowing the good character of the above-identified individual, I recommend him/her to serve as an adult leader for BSA

 Character Reference Signature # 2 Print Name