

**YOUTH HEALTH & MEDICAL RECORD---Camper – BS/CS Staff – BS/CS**

Please sign all areas with this mark \*\*

**Parent/Guardian**

The Boy Scouts of America requires that youth 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 and signed by parent/guardian within **12 months** of the camping experience.

Name of Youth \_\_\_\_\_ Date of Birth \_\_\_\_\_ Unit # \_\_\_\_\_  
Last Name First Name Initial

Youth Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

**IN CASE OF EMERGENCY, NOTIFY:**

Name of parent/guardian \_\_\_\_\_ AM Phone (\_\_\_\_) \_\_\_\_\_  
Home address \_\_\_\_\_ PM Phone (\_\_\_\_) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Pager \_\_\_\_\_

**IF PERSON NAMED ABOVE IS NOT AVAILABLE IN THE EVENT OF AN EMERGENCY, NOTIFY:**

Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ Relationship \_\_\_\_\_  
Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ Relationship \_\_\_\_\_

Medical Provider (Youth) \_\_\_\_\_ Provider Phone (\_\_\_\_) \_\_\_\_\_  
Family Health/Accident Insurance \_\_\_\_\_ Policy No. \_\_\_\_\_

**STATE OF MICHIGAN REQUIRED AUTHORIZATIONS**

The Michigan Department of Consumer and Industry Service pursuant to public Act 116 of 1973 and Administrative Rule 117.(2)(a) REQUIRES the following information.

Authorization is granted for the release of the aforementioned individual to adult employees, camp staff, and volunteers of the La Salle Council, Boy Scouts of America. In addition, to the parents and guardians signing this form, only those individuals listed below are authorized to remove the aforementioned individual from summer camp during their period of camping.

**Please list spouse below if both parents have not signed the authorization below.**

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Name \_\_\_\_\_ Relationship \_\_\_\_\_

The Michigan Department of Consumer and Industry Services pursuant to Public Act 116 of 1973 and administrative Rule 127.1 (1) REQUIRES the following information:

The person herein described is in GOOD HEALTH and has all required immunizations. The information and health history contained herein is accurate and complete. Permission is granted for full participation in BSA programs and activities, subject to limitations noted herein. In the event I (we) cannot be reached in emergency. I (we) hereby grant permission to the medical provider selected by BSA representatives to authorize emergency medical/surgical treatment, routine non-surgical medical care, hospitalization, proper anesthesia and /or medication(s)/injection(s) for my (our) son (daughter). I (we) assume health & financial responsibility for the aforementioned individual.

\*\* Date \_\_\_\_\_ Parent/Guardian Signature \_\_\_\_\_ Print \_\_\_\_\_  
\*\* Date \_\_\_\_\_ Parent/Guardian Signature \_\_\_\_\_ Print \_\_\_\_\_  
\*\* Date \_\_\_\_\_ Parent/Guardian Signature \_\_\_\_\_ Print \_\_\_\_\_

Current signature required EACH YEAR

**YOUTH HEALTH HISTORY**  
(To be completed by Custodial Parent/Guardian)

**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 Bleed	_____ 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 ear, nose or throat infection.	Explain: _____
_____ Current cold or seasonal allergy.	Explain: _____
_____ Current behavioral/emotional concern.	Explain: _____
_____ Other current health concerns.	Explain: _____
_____ Diet Restrictions.	Explain: _____
_____ Activity restrictions.	Explain: _____
_____ Wears contacts.	_____ Wears 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:** \_\_\_\_\_

\*\* Custodial Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

\*\* Custodial Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

\*\* Custodial Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Current year signature required

## CURRENT MEDICATIONS (Prescription & Non-Prescription)

\_\_\_\_\_ My son (daughter) takes NO medications on a routine basis.

My son (daughter) takes the following medications on a regular basis.

Med # 1 \_\_\_\_\_ Dosage \_\_\_\_\_ Times to be given \_\_\_\_\_  
Reason for taking above medication: \_\_\_\_\_

Med # 2 \_\_\_\_\_ Dosage \_\_\_\_\_ Times to be given \_\_\_\_\_  
Reason for taking above medication: \_\_\_\_\_

Med # 3 \_\_\_\_\_ Dosage \_\_\_\_\_ Times to be given \_\_\_\_\_  
Reason for taking above medication: \_\_\_\_\_

Attach additional pages for more medications.

My son (daughter) takes the following medication during the school year but he/she does not take during the summer. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I (we) give permission for my (our) son (daughter) to receive the following over the counter medications as determined by an authorized BSA employee, camp staff or volunteer for purposes of First Aid Safety:

\_\_\_\_\_ NONE                  \_\_\_\_\_ Pain/Fever Reliever                  \_\_\_\_\_ Antihistamines                  \_\_\_\_\_ Anti-diarrheals  
\_\_\_\_\_ Anti-acids                  \_\_\_\_\_ Cough/Cold meds                  \_\_\_\_\_ Topical Antibiotics & Anti-itch Ointments  
\_\_\_\_\_ Other \_\_\_\_\_

\*\* Custodial parent/guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**TO BE COMPLETED BY A LICENSED MEDICAL PROVIDER**

The Boy Scouts of America requires that youth 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 by parent or guardian within **12 months** of the camping experience.

I certify that I have examined \_\_\_\_\_ on \_\_\_\_\_  
Youth 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 if NORMAL: Circle if ABNORMAL and give details below:

_____ Growth, Development	_____ Teeth, Tonsils	_____ Genitourinary
_____ Skin, Glands, Hair	_____ Respiratory	_____ Skeletomuscular
_____ Head, Neck, Thyroid	_____ Cardiovascular	_____ Neuropsychiatric
_____ Eyes, Ears, Nose	_____ Abdomen, Hernia	_____ Other (specify)

Comments: \_\_\_\_\_  
 Restrictions/Limitations: \_\_\_\_\_  
 Provider Signature: \_\_\_\_\_ Name/Phone \_\_\_\_\_

**\*\*\*\*\*COMPLETE ONLY IF CUB/BOY SCOUT STAFF\*\*\*\*\***

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

Camp Staff Member's Name \_\_\_\_\_  
Registered position in Council \_\_\_\_\_  
Position in Camp \_\_\_\_\_

**PLEASE INDICATE TRAINING RECEIVED AND DATE ISSUED:**

Life Saving Merit Badge	_____	CPR BLS Certified	_____
BSA Life Guard	_____	Safe Swim Defense training	_____
ARC Basic Water Safety	_____	ARC 1 <sup>st</sup> Aid Prof. Rescue	_____
ARC Advanced Swimmer	_____	ARC Life Guard Instructor	_____
ARC Water Safety Instructor	_____		
ARC First Aid	_____		
ARC Life Guard	_____		

Have you ever been convicted of anything other than a minor traffic violation? Yes\_\_\_\_ No\_\_\_\_

If yes, please explain \_\_\_\_\_

The information contained in this form is correct to the best of my knowledge.

Date \_\_\_\_\_ Signed \_\_\_\_\_, Staff Member

Date: \_\_\_\_\_ Signed \_\_\_\_\_, Parent if under 18

**REFERENCES FOR CAMP STAFF (Must be completed prior to camp)**

As a representative for the above named individual's unit, I recommend him/her to serve as staff at Camp Tamarack, Wood Lake Scout Reservation.		
_____	_____	_____
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 a staff member at Camp Tamarack, Wood Lake Scout Reservation.	
_____	_____
Character Reference Signature # 1	Print Name

Knowing the good character of the above-identified individual, I recommend him/her to serve as a staff member at Camp Tamarack, Wood Lake Scout Reservation.	
_____	_____
Character Reference Signature # 2	Print Name