

Attach Immunization record here

Baden-Powell Council
Personal Health and Medical Record Form

Identification:

In an emergency notify:

Name:
Address:
City & State: Zip
Date of Birth Sex
Pack/Troop/Post #
Health/Accident Insurance Policy #

Name
Relationship
Day Phone:
Evening Phone:
Work Phone or Cell: Other
emergency contact names please attach separate page.

Youth: please attach a copy of the Immunization record including Hepatitis B
Adult Immunizations:
Please list month/year for:
Tetanus: Measles: Mumps:
Hepatitis B:
Diphtheria: Chicken Pox:

Emergency Medical Information:
Has or is subject to (check and give details):
Convulsions or seizures Heart Trouble
Fainting Spells Asthma
Earache/infections Diabetes
Shortness of breath Hay Fever
Communicable Disease Allergy

This Health History is correct to the best of my knowledge. I give permission to participate in all activities, except those noted. I give permission to the authorized personnel at Camp to administer immediate first aid. In the event that I cannot be contacted in an emergency, I hereby give my permission to the physician selected by camp to secure proper treatment.

Explain:
Has it ever been necessary to restrict activities for medical reasons? No Yes
Explain:

Signature (Parent/guardian if under 18) Date:

If participating in Day Camp, Overnighter, or a Resident Camp <72 continuous hours stop here. (Class 1)
If participating in a Resident Camp over 72 continuous hours a Health Examination is necessary (Class 2&3)

Medical History: To be completed by Parent (or applicant if 18 or older) prior to Health examination.
Are you aware of any current health Problems?
Currently under medical care or taking medications?
Is there disease of (past or present history):
Serious Illness: Y N: year Details:
Serious Injury: Y N: year Details:
Deformity: Y N: year Details:
Surgery: Y N: year Details:
Skin, glands: Y N: year Details:
Eyes, ears, nose, sinus: Y N: year Details:
Teeth, tonsils (dentures/bridge): Y N: year
Chest, lungs: Y N: year Details:
Heart (murmur/Rheumatic fever): Y N: year
Details:
Stomach, bowels: Y N: year Details:
Kidneys, urine: Y N: year Details:
Albumin / Sugar / Infection / bed wetting (circle)
Menstrual problems: Y N: year Details:
Hernia (rupture): Y N: year Details:
Back, limb, joints: Y N: year Details:
Sleepwalking: Y N: year Details:
Nervous Condition: Y N: year Details:
Other: year Details:

Health Examination:
Licensed Health-Care Provider: The applicant will be participating in a strenuous activity that will include one or more of the following conditions: Athletic competition, adventure challenges that may include high altitude, extreme weather, cold water, exposure, fatigue and or remote conditions where readily available medical care cannot be assured. Please review complete medical history and immunization records prior to signing below.
Ht. Wt. Vision: Normal
BP Pulse Glasses contacts
Hearing: Normal Abnormal
Check if normal, circle if abnormal and give details:
growth/development Teeth, tonsils Genitourinary
head, neck, thyroid Respiratory skeletomuscular
abdomen, hernia, rings Cardiovascular neuropsychiatric
Eyes, ears, throat Skin, glands, hair other
Comments:
Please fill out the reverse side of this form for all medications participant may be given at camp - both prescription and over-the-counter medications are included.

Approved for Hiking & Camping Sports Water Activities All Activities Exemptions:
Recommendations:

Signature Licensed Health Care Provider: Date:

If participating in a high-adventure program or you are over 40, stop here. Physical is only good for 1 year: (class3)

For all others, this form is valid for 3 years from date of the physical exam as long as it is reviewed annually:(class 2)

I have reviewed the above information and updated it as appropriate:

Signature (Parent/guardian) if under 18 Date: (year 2)
Signature (Parent/guardian) if under 18 Date: (year 3)

Baden-Powell Council – Medication Permission Form

Dear Parent or Guardian,

If you wish you or your child to receive ANY medication during camp, NYS regulations require written permission from your health care provider. This includes both prescription and over-the-counter medications, and must be renewed annually.

NAME _____ Date of Birth _____

TO BE COMPLETED BY A LISCENSED HEALTH CARE PRESCRIBER:

Medication: _____
 Dosage: _____ Time or Times of administration: _____

Medication: _____
 Dosage: _____ Time or Times of administration: _____

Medication: _____
 Dosage: _____ Time or Times of administration: _____

Please duplicate this form if more than 3 prescription medications are prescribed.

The following is a list of over-the-counter medications available for dispensing at camp. Please indicate with a check mark if this patient may receive any of these medications.*

Year1	Year2	Year3	Medication
			Acetaminophen as directed Q4hr PRN temp<101, minor pain or discomfort.
			Ibuprofen 200mg-400mg Q4hr PRN minor pain or discomfort.
			Benzocaine Oral Anesthetic Lozenges.
			Benadryl Elixir/Tab 12.5-25mg PO Q6-8HR (5mg/kg/24hr) PRN not to exceed 300mg/24hr, minor allergic reaction.
			Neosporin/Bacitracin Antibiotic Ointment apply topically to affected area PRN minor cuts/abrasions.
			Calacryl/Calahist lotion applied topically to affected area PRN minor itching.
			Pepto Bismol Chewable Tablets or liquid after each loose BM
			“After Bite” (Ammonium Hydroxide) apply topically to insect bites PRN itching
			A&D Ointment to affected area PRN minor skin itching

* Note: If there are any changes in medications or other medical information after this form has been submitted, please notify the camp in writing. Also, if you change physicians, please provide their contact information *(same format as below) in writing.

Physician/Practitioner Signature: _____ Date: _____
 Year 2: _____ Date: _____
 Year 3: _____ Date: _____

*Please print: Name _____
 Address: _____
 Phone: _____