



BOY SCOUTS OF AMERICA®

MAYFLOWER COUNCIL

SUMMER CAMP MEDICAL FORM INSTRUCTIONS

Accurate medical records for campers and staff are required by BSA standards and are also critical to ensure timely, effective care should you or your Scout become sick or injured while at camp. All campers, adult leaders and staff **MUST** complete the BSA Annual Health and Medical Record form annually. Forms expire after 12 months.

Scouts, leaders, parents, and visitors WILL NOT PARTICIPATE in many camp activities including (but not limited to) swimming, boating, climbing, COPE, and sports, and may not remain in camp longer than 72 hours without a completed medical form.

Read the medical form carefully. The next page highlights areas that are commonly incomplete. All portions of the form must be completed for ALL summer camp programs.

Please take note of the following changes:

PART A:

This page contains an important risk advisory, informed consent, and release. Please read this advisory carefully. The participant and parents (if participant is under 18) must sign to acknowledge agreement with the information on this page.

This page also includes space to list adults who are authorized (or prohibited) to take this participant to/from events.

PART B:

Part B contains the participant's contact and insurance information and generic health history. Page 2 of this section contains information about medication and allergies. Please complete these sections carefully and accurately. The parents and health care professional must sign to authorize all medication.

PART C:

Part C is the annual physical. This page should be completed and signed by the health care professional conducting the physical examination. Physicals are required within 12 months of an event lasting longer than 72 hours.

COMMON MISTAKES:

- Missing parent/guardian signature (Part A)
- Missing emergency contact information (Part B)
- Incomplete medication information (Part B)
- Missing medical insurance card (Part B)
- Missing immunization record (Part B)
- Missing physician signature (Part B & C)
- Physical exam more than 12 months ago (Part C)

NOTE: State regulations require that your complete immunization record be on file with the local health department.

MEDICAL FORMS ARE NOT RETURNED AT THE END OF CAMP. Always submit a **COPY** of your medical form. Keep the original for use at other Scouting activities.

PART A - Page 1

Part A: Informed Consent, Release Agreement, and Authorization

High-adventure base participants:
 Full name: _____ Expedition/Team No. _____
 or staff position: _____
 DOB: _____

Participant and parents (if participant is under 18) must sign to acknowledge the informed consent and release on this page.

With appreciation of the dangers and risks associated with programs and activities, on my own behalf and on behalf of my child, I hereby fully and completely release and waive any and all claims for personal injury, death, or loss that may arise against the Boy Scouts of America, the local council, the activity coordinators, and all employees, volunteers, outside parties, or other organizations associated with any program or activity.

I also hereby assign and grant to the local council and the Boy Scouts of America, as well as their authorized representatives, the right and permission to use and publish the photographic and video electronic representations and audio recordings made during or in the context of all scouting activities, and hereby release the Boy Scouts of America, the local council, the activity coordinators, and all employees, volunteers, outside parties, or other organizations associated with the activity from any and all liability from such use and publication. I further authorize the reproduction, sale, copyright, rental, investment, storage, archiving, and distribution of such photographic and video electronic representations and audio recordings without limitation of the disclosure of the photo, and specifically waive any right to any compensation I may have for any of the foregoing.

NOTE: Due to the nature of programs and activities, the Boy Scouts of America and local councils cannot continuously monitor compliance of program participants or any individuals registered upon them by quality or medical personnel, insofar as that leaders can be as limited as possible with any limitations, but any restrictions imposed on a child participant in connection with programs or activities shall be noted on the front of this form.

List participant restrictions, if any _____

I hereby authorize the sharing of information on this form with any state, territorial, or professional who need to know of my child's condition that may require special consideration in conducting scouting activities.

I understand that, if any information on this form is not to be disclosed, I may not and/or withdraw the opportunity for participation in any event or activity if I am participating at Parkettes, Intensive Training Center, Scout Executive Institute, Florida Sea Base, or the National District Institute. I also understand that the participant will not be allowed to participate in activities, high-adventure programs if those restrictions are not noted. The participant will not be allowed to participate in activities if no signature is provided on this form to indicate that the parent/guardian or the participant is under the age of 18, and a parent/guardian signature is required.

Participant's signature: _____
 Parent/guardian signature for youth: _____
 Second parent/guardian signature for youth: _____

Complete this section for youth participants only:
Adults Authorized to Take to and from Events:
 Name: _____ Signature: _____
Adults NOT Authorized to Take Youth to and from Events:
 Name: _____ Signature: _____

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PART B - Page 1

Part B: General Information/Health History

Include insurance information and attach a copy of the participant's insurance card.

High-adventure base participants:
 Full name: _____ Expedition/Team No. _____
 or staff position: _____
 DOB: _____

Please attach a photocopy of both sides of the insurance card. If you do not have medical insurance, enter "none" above.
 In case of emergency, notify the person below:

Name: _____ Telephone: _____
 Address: _____ Home phone: _____ Other phone: _____
 Alternate contact name: _____ Alternative phone: _____

Health History

Do you currently take or have you ever taken (check any of the following)?

Yes	No	Condition	Special
<input type="checkbox"/>	<input type="checkbox"/>	Cholesterol	Last Cholesterol percentage and date:
<input type="checkbox"/>	<input type="checkbox"/>	High-altitude (high blood pressure)	
<input type="checkbox"/>	<input type="checkbox"/>	Adult or congenital heart (heart/heart attack/heart pain/anginal/heart trouble/irregular/slow/fast heart/rhythm or problems / issues) or other cardiac condition	Last attack date:
<input type="checkbox"/>	<input type="checkbox"/>	Family history of heart disease or any other heart-related issue or a family member before age 55	
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding/bruising	
<input type="checkbox"/>	<input type="checkbox"/>	Allergies	
<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Issues	
<input type="checkbox"/>	<input type="checkbox"/>	COVID-19	
<input type="checkbox"/>	<input type="checkbox"/>	High/low blood pressure	
<input type="checkbox"/>	<input type="checkbox"/>	Uncontrolled condition/issue or other issue	
<input type="checkbox"/>	<input type="checkbox"/>	Fatigue/tiredness	
<input type="checkbox"/>	<input type="checkbox"/>	Headaches	
<input type="checkbox"/>	<input type="checkbox"/>	Phonophobia/audiophobia or other auditory condition	
<input type="checkbox"/>	<input type="checkbox"/>	Severe claustrophobia or other phobia	
<input type="checkbox"/>	<input type="checkbox"/>	Severe motion sickness or other condition	
<input type="checkbox"/>	<input type="checkbox"/>	Severe altitude sickness	
<input type="checkbox"/>	<input type="checkbox"/>	Severe cold/flu symptoms	
<input type="checkbox"/>	<input type="checkbox"/>	Severe ear pain or other condition	
<input type="checkbox"/>	<input type="checkbox"/>	Severe stomach issues	
<input type="checkbox"/>	<input type="checkbox"/>	Severe back pain or other condition	
<input type="checkbox"/>	<input type="checkbox"/>	Severe joint pain or other condition	
<input type="checkbox"/>	<input type="checkbox"/>	Severe skin issues	
<input type="checkbox"/>	<input type="checkbox"/>	Severe respiratory issues	
<input type="checkbox"/>	<input type="checkbox"/>	Severe digestive issues	
<input type="checkbox"/>	<input type="checkbox"/>	Severe autoimmune conditions	
<input type="checkbox"/>	<input type="checkbox"/>	Severe diabetes	
<input type="checkbox"/>	<input type="checkbox"/>	Severe vision issues	
<input type="checkbox"/>	<input type="checkbox"/>	Severe hearing issues	
<input type="checkbox"/>	<input type="checkbox"/>	Severe dizziness	
<input type="checkbox"/>	<input type="checkbox"/>	Severe depression	
<input type="checkbox"/>	<input type="checkbox"/>	Severe anxiety	
<input type="checkbox"/>	<input type="checkbox"/>	Severe chronic conditions	
<input type="checkbox"/>	<input type="checkbox"/>	Severe other medical conditions	

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PART B - Page 2

Part B: General Information/Health History

List all allergies, and medications taken here.

High-adventure base participants:
 Full name: _____ Expedition/Team No. _____
 or staff position: _____
 DOB: _____

Allergies/Medications

Yes	No	Allergies or Reactions	Hygiene	Medication	Other
<input type="checkbox"/>	<input type="checkbox"/>	Food	<input type="checkbox"/>	Medication	Other
<input type="checkbox"/>	<input type="checkbox"/>	Latex	<input type="checkbox"/>	Prescription	Other
<input type="checkbox"/>	<input type="checkbox"/>	Animal	<input type="checkbox"/>	Over-the-counter	Other

List all medications currently used, including any over-the-counter medications.
 CHECK HERE IF NO MEDICATIONS ARE ROUTINELY TAKEN. IF ADDITIONAL SPACE IS NEEDED, PLEASE INDICATE ON A SEPARATE SHEET AND ATTACH.

Medication	Dose	Frequency	Notes

Bring enough medications in sufficient quantities and in the original containers. Make sure that they are NOT expired, including inhalers. Medication must be taken as directed. You SHOULD NOT STOP taking any maintenance medication unless instructed to do so by your physician.

Parent and physician must sign to authorize medication.

Parent/guardian signature: _____
 Participant signature: _____
 Doctor/Physician signature: _____

DO NOT WRITE IN THIS BOX
 Name of parent/guardian: _____
 Signature by: _____
 Title: _____
 Date: _____
 Signature by: _____
 Title: _____
 Date: _____

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PART C - Page 1

Part C: Pre-Participation Physical

Health care professional completes this page.

This part must be completed by certified and licensed physicians (MD or DO) or other health care professionals.

High-adventure base participants:
 Full name: _____ Expedition/Team No. _____
 or staff position: _____
 DOB: _____

You are being asked to certify that this individual has no contraindications for participation in a scouting experience. For individuals who will be attending a high-adventure program, including one of the national high-adventure bases, please refer to the supplemental information on the following pages or the form provided by your parent.

Examiner: Please fill in the following information:

Yes	No	Condition	Special
<input type="checkbox"/>	<input type="checkbox"/>	Medical conditions that preclude	
<input type="checkbox"/>	<input type="checkbox"/>	Allergies or Reactions	
<input type="checkbox"/>	<input type="checkbox"/>	Height	
<input type="checkbox"/>	<input type="checkbox"/>	Weight	
<input type="checkbox"/>	<input type="checkbox"/>	BMI	
<input type="checkbox"/>	<input type="checkbox"/>	Blood Pressure	
<input type="checkbox"/>	<input type="checkbox"/>	Pulse	

Examiner's Certification

I certify that I have reviewed the health history and examined this person and that no contraindications for participation in a scouting experience. This participant meets all requirements for participation in the following experience. The participant meets all requirements for participation in the following experience.

Health care professional must sign here.

Examiner's Signature: _____ Date: _____
 Provider printed name: _____
 Address: _____
 City: _____ State: _____ ZIP code: _____
 Other phone: _____

Height/Weight Restrictions
 If you exceed the maximum weight for height as indicated in the following chart and your planned high-adventure activity will take you more than 30 minutes away from an emergency medical/evacuation facility, you may not be allowed to participate.

Maximum weight for height	Height (feet/in)	Max. weight	Height (feet/in)	Max. weight	Height (feet/in)	Max. weight
42	4'0"	100	4'6"	130	5'0"	160
44	4'6"	130	5'0"	160	5'6"	200
46	5'0"	160	5'6"	200	6'0"	250
48	5'6"	200	6'0"	250	6'6"	300
50	6'0"	250	6'6"	300	7'0"	350
52	6'6"	300	7'0"	350	7'6"	400
54	7'0"	350	7'6"	400	8'0"	450

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