

**++Attach Immunization record here
Please include copy of insurance card**

**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 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. I give permission to participate in all activities, except those noted.

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

Participant 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)**

<p>Medical History: To be completed by Parent (or applicant if 18 or older) prior to Health examination.</p> <p>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: _____</p>	<p>Health Examination: <i>Licensed Health-Care Provider:</i> 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.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>Ht. _____ Wt. _____</td> <td>Vision: ___ Normal</td> </tr> <tr> <td>BP _____ Pulse _____</td> <td>___ Glasses ___ contacts</td> </tr> <tr> <td></td> <td>Hearing: ___ Normal ___ Abnormal</td> </tr> </table> <p>Check if normal, circle if abnormal and give details:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>___ growth/development</td> <td>___ Teeth, tonsils</td> <td>___ Genitourinary</td> </tr> <tr> <td>___ head, neck, thyroid</td> <td>___ Respiratory</td> <td>___ skeletal/muscular</td> </tr> <tr> <td>___ abdomen, hernia, rings</td> <td>___ Cardiovascular</td> <td>___ neuropsychiatric</td> </tr> <tr> <td>___ Eyes, ears, throat</td> <td>___ Skin, glands, hair</td> <td>___ other</td> </tr> </table> <p>Comments: _____ _____</p> <p>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.</p>	Ht. _____ Wt. _____	Vision: ___ Normal	BP _____ Pulse _____	___ Glasses ___ contacts		Hearing: ___ Normal ___ Abnormal	___ growth/development	___ Teeth, tonsils	___ Genitourinary	___ head, neck, thyroid	___ Respiratory	___ skeletal/muscular	___ abdomen, hernia, rings	___ Cardiovascular	___ neuropsychiatric	___ Eyes, ears, throat	___ Skin, glands, hair	___ other
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Approved for ___ Hiking & Camping ___ Sports ___ Water Activities ___ All Activities
Please state any 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:
Participant Signature (Parent/guardian if under 18) _____ Date: _____ (year 2)
Participant Signature (Parent/guardian if under 18) _____ Date: _____ (year 3)

Baden-Powell Council – Medication Permission Form

Dear Parent or Guardian,

If you wish for 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.

All prescriptions must be in packaging with original pharmacy label affixed.

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.*

Please check only 1 year at a time

Medication	Year 1	Year 2	Year 3
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			
Caladryl/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 Year 1: _____ Date: _____
 Year 2: _____ Date: _____
 Year 3: _____ Date: _____

*Please print: Physician’s Name: _____
 Address: _____
 Phone: _____