Name: ______ Last Name ______ First ______ Troop #: ______ Campsite: ______

ADULT PERSONAL HEALTH and MEDICAL RECORD

CLASS 2 REVISED

Dear Scout Leader:

We need the information requested in this form for your safety and the safety of the Scouts you are camping with. We also want to eliminate the cost of unnecessary visits to your physician.

Northern Star Council/BSA and the State of Wisconsin require that:
Adult campers over 18 and under 40 years of age have a medical evaluation by a licensed physician within the **last 36 months**, attested to by a medical doctor.

Adult campers over 40 years of age must have a medical evaluation within the last 12 months.

This form MUST BE UPDATED AND SIGNED EACH YEAR BY YOU – regardless of the date of physical exam.

MUST BE COMPLETED BY ADULT CAMPER

1. Have you had a medical evaluation (physical examination) within the last:
   36 months if 18-40 years old or 12 months if over 40 years old?
   - ❒ Yes - Date of last exam: Month:________________ Year:____________.
     Clinic Name:____ Phone # (____) ______________
   - ❒ No - Please complete pages 2 & 3, and then complete a physical examination with a physician currently licensed to practice medicine. The doctor should complete the medical evaluation found on page 4.
2. Has you had a **tetanus shot** in the last 10 years?
   - ❒ Yes -Please **write the date** you received your last immunization on page 3.
   - ❒ No - Please schedule an appointment with a physician to receive a tetanus inoculation (or booster) at least 2 weeks before you attend camp. Be sure to indicate the date you received the tetanus shot on page 3.
3. Have you been told by a physician that you should not participate in **strenuous activities**?
   - ❒ No -
   - ❒ Yes - Please write on page 3 what specific limitations you have so the medical staff is aware of them.
4. Are you **currently being treated** by a physician?
   - ❒ No -
   - ❒ Yes - Please provide a statement from your physician indicating what current treatment is being given. This may be in the form of a letter or use page 4 of this form.
5. Are you taking prescribed medication regularly?
   - ❒ No -
   - ❒ Yes - Please provide a statement from your physician indicating present prescribed medicine, including how, why and when it should be administered while your son is in camp.
6. Are you on a **prescribed meal** plan?
   - ❒ No -
   - ❒ Yes - Please provide a copy of your diet to assist our commissary in preparing meals to meet your needs.
7. Have you **lost consciousness** during physical activity or had a concussion due to a head injury?
   - ❒ No -
   - ❒ Yes - Please provide a current statement from a physician on the injury and current symptoms. This may be a letter or use page 4 of this form.
8. Have you had an **illness or injury** within the last 6 months that limited your activity longer than one week?
   - ❒ No - **Please sign the lines below.**
   - ❒ Yes -Provide an updated, current medical evaluation from your doctor. Please sign the lines below.

The answers to these questions **are current and correct** to my best knowledge regarding my health:

Print your full name:____

____ DATE:____________________

Signed

For adults under 40 years of age:

"I have reviewed the information on pages 2 & 3 regarding my health, including the emergency treatment statement, and have noted any changes in the last year."

Second year update:____ Date:____________________

Third year update:____ Date:____________________

HEALTH AND MEDICAL SUMMARY

MUST BE COMPLETED by applicant

IDENTIFICATION:

Name____________________ Date of Birth __________ Age ______ Sex______

Name of parent or guardian ____________________ Telephone (_____)________

Home address____________________ City __________ State _____Zip______

Daytime/Business Telephone(s) (_____)____________________

****In the event of an emergency, notify:**

Name____________________Relationship__________Telephone (___) ________

Name____________________Relationship__________Telephone (___) ________

Name of personal physician____________________ Telephone (_______) ________

Name of Clinic______________________________

Personal Health/Accident insurance carrier____________________Policy #__________

In case of emergency, I understand every effort will be made to with me or the responsible people listed above. In the event I am unable to respond, I hereby give my permission to the physician selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery and injections of medication.

Date:____________ Signature: ______________________________

MEDICAL INFORMATION: past or present (please circle)

Asthma	Yes	No	Diabetes	Yes	No	Hemophilia	Yes	No
Heart Disease	Yes	No	High Blood Pressure	Yes	No	**Other:**______	Yes	No
Convulsions	Yes	No	Cancer	Yes	No	__________		

Explanations______________________________

____

Any reason to restrict full activity including swimming, long hikes, backpacking, strenuous physical games? ❐ Yes ❐ No

List any conditions limiting full participation (physical or emotional)____________________

____

ALLERGIES: to Foods, Plants, Insects, Medicines, etc: ❐Yes ❐ No Is any allergy severe? ❐ Yes ❐ No

Explanations______________________________

____

MEDICINES:

Are any medicines to be taken at camp? ❐ Yes ❐ No

List ALL medicines. Send ample supplies and directions for use. ____________________

____

Any special equipment such as orthopedic or handicap devices, glasses or contacts, dentures? ❐ Yes ❐ No

Please list:______________________________

IMMUNIZATIONS: Please write the date of last inoculation or disease:

***Tetanus Toxoid** __________	Polio __________	Mumps __________
Diphtheria __________	Pertussis __________	Measles __________
Chicken Pox __________		Rubella __________

*** Mandatory immunization within 10 years**

MEDICAL EVALUATION

To be filled out by physician

Name____ Age __________

NOTE TO PHYSICIAN: The person being evaluated will be attending one or more weeks of camp that may include sleeping on the ground, participating in strenuous activities such as hiking, boating, and vigorous group games. Please include an EKG report dated within 12 months, if warranted.

PHYSICAL EXAMINATION

Height______________ Weight______________ BP ________ / ________

Lab: Urinalysis (dipstick) Albumin ______________ Sugar ______________

VISION: Normal__________ HEARING: Normal__________

Glasses__________ Abnormal__________

Contacts__________

Check box if normal and circle if abnormal

Growth development	❑	Ears, nose	❑	Heart	❑	Musculo skeletal	❑
Skin, glands	❑	Teeth, tonsils	❑	Hernia	❑	Eyes	❑
Thyroid, head, neck	❑	Lungs	❑	Genitalia	❑	Other	❑

EXPLAIN ANY ABNORMAL FINDING____

____

____

____

____

____

____

Limitations:

Activity restrictions: ____

Diet restrictions:____

Signature______________________________M.D./D.O. Date______________

Physician's Name (print/type)____

Clinic Address______________________________ Phone______________

City, State, Zip____

	INTERVAL RECORD	
DATE, TIME, PLACE, ETC	(findings, diagnoses, treatment, instructions, dispositions, etc.)	BY

J:\Class 2 Adult Medical Ledger.doc