Annual Health and Medical Record - Part A - Informed Consent, Release Agreement, and Authorization

Name ______________________ Date of Birth ______________ Camp______________

I understand that participation in Scouting activities involves the risk of personal injury, including death, due to the physical, mental, and emotional challenges in the activities offered. Information about those activities may be obtained from the venue, activity coordinators, or your local council. I also understand that participation in these activities is entirely voluntary and requires participants to follow instructions and abide by all applicable rules and the standards of conduct.

In case of an emergency involving me or my child, I understand that efforts will be made to contact the individual listed as the emergency contact person by the medical provider and/or adult leader. In the event that this person cannot be reached, permission is hereby given to the medical provider selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for me or my child. Medical providers are authorized to disclose protected health information to the adult in charge, camp medical staff, camp management, and/or any physician or health-care provider involved in providing medical care to the participant. Protected Health Information/ Confidential Health Information (PHI/CHI) under the Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. §§160.103, 164.501, etc. seq., as amended from time to time, includes examination findings, test results, and treatment provided for purposes of medical evaluation of the participant, follow-up and communication with the participant's parents or guardian, and/or determination of the participant's ability to continue in the program activities.

I have carefully considered the risk involved and hereby give my informed consent for my child to participate in all activities offered in the program. I further authorize the sharing of the information on this form with any BSA volunteers or professionals who need to know of medical conditions that may require special consideration in conducting Scouting activities.

With appreciation of the dangers and risks associated with programs and activities, on my own behalf and/or 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, related 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 photographs/film/videotapes/electronic representations and/or sound recordings made of me or my child at all Scouting activities, and I hereby release the Boy Scouts of America, the local council, the activity coordinators, and all employees, volunteers, related 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, exhibit, broadcast, electronic storage, and/or distribution of said photographs/film/videotapes/electronic representations and/or sound recordings without limitation at the discretion of the BSA, and I 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 continually monitor compliance of program participants or any limitations imposed upon them by parents or medical providers. However, so that leaders can be as familiar as possible with any limitations, list any restrictions imposed on a child participant in connection with programs or activities below.

I understand that, if any information I/we have provided is found to be inaccurate, it may limit and/or eliminate the opportunity for participation in any event or activity. If the participant is under the age of 18, a parent or guardian's signature is required.

List participant restrictions, if any: ______________________

Part B - General Information/Health History

Age ______ O Male O Female Unit No. ______

Address ______________________ Grade completed (youth only) ______

City ______________ State ______ Zip ______ Phone ______

Unit Leader ______________________ Phone ______

Health/acident insurance company ______________ Policy No. ______

ATTACH A PHOTOCOPY OF BOTH SIDES OF INSURANCE CARD. IF YOU DO NOT HAVE MEDICAL INSURANCE ENTER "NONE" ABOVE.

In case of emergency, notify:

Name ______________________ Relationship ______

Address ______________________

Home phone ______ Business phone ______ Mobile phone ______

Alternate contact name ______________ Alternate's phone ______

Health History

Do you currently have, or have you ever been treated for any of the following? Add pages for explanation.

O Yes O No Diabetes Last HbA1C: (%) ______	O Yes O No Ear/eyes/nose/sinus problems	O Yes O No Kidney disease
O Yes O No Hypertension (High blood pressure)	O Yes O No Muscular/skeletal condition	O Yes O No Seizures Last seizure: (mm/yy) ______
O Yes O No Heart Disease /heat attack/chest pain/heart mumur/procedure	O Yes O No Head injury/concussion	O Yes O No Abdominal/digestive problems
O Yes O No Family History of heart disease or sudden heart related death	O Yes O No Altitude sickness	O Yes O No Thyroid disease
O Yes O No Stroke/TIA	O Yes O No Psychiatric/psychological / emotional difficulties	O Yes O No Excessive fatigue
O Yes O No Asthma Last attack: (mm/yy) ______	O Yes O No Behavioral/neurological disorders	O Yes O No Sleep disorders (e.g., sleep apnea) Use CPAP? O Yes O No
O Yes O No Lung/respiratory disease	O Yes O No Blood disorders/sickle cell disease	O Yes O No Surgery Hospitalization Last surgery: (mm/yy) ______
O Yes O No COPD	O Yes O No Fainting spells and dizziness	O Yes O No Other

Are you allergic to or do you have adverse reaction to any of the following?

O Yes O No Medication ______ O Yes O No Plants ______ O Yes O No Insects ______ O Yes O No Food ______

MEDICATIONS List all medications currently used, including over the counter medications. O No medications

Medication ______	Medication ______	Medication ______
Strength ______ Frequency ______	Strength ______ Frequency ______	Strength ______ Frequency ______
Approximate date started ______	Approximate date started ______	Approximate date started ______
Reason for medication ______	Reason for medication ______	Reason for medication ______

Administration of the above medications is approved for youth by: ______________

Bring enough medications in sufficient quantities and in the original containers. Make sure that they are NOT expired, including inhalers and EpiPens. You SHOULD NOT STOP taking any maintenance medication unless instructed to do so by your doctor.

The following immunizations are recommended by the BSA. Tetanus immunization is required and must have been received within the last 10 years. If you had the disease, check the disease column and list the date. If immunized, check yes and provide the year received.

Immunized	Date	Had Disease?	Date	Immunized	Date	Had Disease?		Immunized	Date	Had Disease?	Date
O Yes O No Tetanus	______	O Yes O No	______	O Yes O No Polio	______	O Yes O No	______	O Yes O No Meningitis	______	O Yes O No	______
O Yes O No Pertussis	______	O Yes O No	______	O Yes O No Chicken Pox	______	O Yes O No	______	O Yes O No Influenza	______	O Yes O No	______
O Yes O No Diphtheria	______	O Yes O No	______	O Yes O No Hepatitis A	______	O Yes O No	______	O Yes O No Other (i.e., HIB)	______	O Yes O No	______
O Yes O No Measles/mumps/rubella		O Yes O No	______	O Yes O No Hepatitis B	______	O Yes O No			______		

O Exception to immunizations claimed (form required). http://www.scouting.org/filestore/pdf/680-451.pdf

California Penal Code Section 19915 (a) Every person who furnishes any BB device to any minor, without the express or implied permission of a parent or legal guardian of the minor, is guilty of a misdemeanor.

I give my permission for this child to participate in Archery or BB Guns at this Day Camp. Not all camps do all of these activities.

Adults authorized to take youth to and from events: You must designate at least one adult. Please include a telephone number.

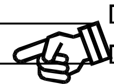
1. Name ______________________ Telephone ______
2. Name ______________________ Telephone ______
3. Name ______________________ Telephone ______

Adults NOT authorized to take youth to and from events:

1. Name ______________________ Telephone ______
2. Name ______________________ Telephone ______
3. Name ______________________ Telephone ______

Participant's name ______________________

Participant's signature ______________________ Date ______

Parent/guardian's signature ______________________  Date ______

Second parent/guardian signature ______________________ Date ______