

# Part A: Informed Consent, Release Agreement, and Authorization

Full name: \_\_\_\_\_  
DOB: \_\_\_\_\_

**High-adventure base participants:**  
Expedition/crew No.: \_\_\_\_\_  
or staff position: \_\_\_\_\_

**Informed Consent, Release Agreement, and Authorization**  
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.

(If applicable) 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.**

List participant restrictions, if any:  None

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 I am participating at Philmont, Philmont Training Center, Northern Tier, Florida Sea Base, or the Summit Bechtel Reserve, I have also read and understand the supplemental risk advisories, including height and weight requirements and restrictions, and understand that the participant will not be allowed to participate in applicable high-adventure programs if those requirements are not met. The participant has permission to engage in all high-adventure activities described, except as specifically noted by me or the health-care provider. If the participant is under the age of 18, a parent or guardian's signature is required.

Participant's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/guardian signature for youth: \_\_\_\_\_ Date: \_\_\_\_\_

(If participant is under the age of 18)

Second parent/guardian signature for youth: \_\_\_\_\_ Date: \_\_\_\_\_

(If required; for example, California)

## Complete this section for youth participants only:

**Adults Authorized to Take to and From Events:**  
You must designate at least one adult. Please include a telephone number.

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Telephone: \_\_\_\_\_ Telephone: \_\_\_\_\_

**Adults NOT Authorized to Take Youth To and From Events:**

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Telephone: \_\_\_\_\_ Telephone: \_\_\_\_\_



# Part B: General Information/Health History

**Full name:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

**High-adventure base participants:**  
 Expedition/crew No.: \_\_\_\_\_  
 or staff position: \_\_\_\_\_

Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Height (inches): \_\_\_\_\_ Weight (lbs.): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP code: \_\_\_\_\_ Telephone: \_\_\_\_\_

Unit leader: \_\_\_\_\_ Mobile phone: \_\_\_\_\_

Council Name/No.: \_\_\_\_\_ Unit No.: \_\_\_\_\_

Health/Accident Insurance Company: \_\_\_\_\_ Policy No.: \_\_\_\_\_



**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: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Home phone: \_\_\_\_\_ Other phone: \_\_\_\_\_

Alternate contact name: \_\_\_\_\_ Alternate's phone: \_\_\_\_\_

## Health History

Do you currently have or have you ever been treated for any of the following?

Yes	No	Condition	Explain
		Diabetes	<b>Last HbA1c percentage and date:</b>
		Hypertension (high blood pressure)	
		Adult or congenital heart disease/heart attack/chest pain (angina)/heart murmur/coronary artery disease. Any heart surgery or procedure. Explain all "yes" answers.	
		Family history of heart disease or any sudden heart-related death of a family member before age 50.	
		Stroke/TIA	
		Asthma	<b>Last attack date:</b>
		Lung/respiratory disease	
		COPD	
		Ear/eyes/nose/sinus problems	
		Muscular/skeletal condition/muscle or bone issues	
		Head injury/concussion	
		Altitude sickness	
		Psychiatric/psychological or emotional difficulties	
		Behavioral/neurological disorders	
		Blood disorders/sickle cell disease	
		Fainting spells and dizziness	
		Kidney disease	
		Seizures	<b>Last seizure date:</b>
		Abdominal/stomach/digestive problems	
		Thyroid disease	
		Excessive fatigue	
		Obstructive sleep apnea/sleep disorders	<b>CPAP: Yes <input type="checkbox"/> No <input type="checkbox"/></b>
		List all surgeries and hospitalizations	<b>Last surgery date:</b>
		List any other medical conditions not covered above	



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## Part B: General Information/Health History

Full name: \_\_\_\_\_  
 DOB: \_\_\_\_\_

**High-adventure base participants:**  
 Expedition/crew No.: \_\_\_\_\_  
 or staff position: \_\_\_\_\_

### Allergies/Medications

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

Yes	No	Allergies or Reactions	Explain	Yes	No	Allergies or Reactions	Explain
		Medication				Plants	
		Food				Insect bites/stings	

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	Reason

YES  NO Non-prescription medication administration is authorized with these exceptions: \_\_\_\_\_

Administration of the above medications is approved for youth by:

\_\_\_\_\_/\_\_\_\_\_  
 Parent/guardian signature MD/DO, NP, or PA signature (if your state requires signature)

**!** 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. **!**

### Immunization

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.

Yes	No	Had Disease	Immunization	Date(s)	Please list any additional information about your medical history:
			Tetanus		
			Pertussis		
			Diphtheria		
			Measles/mumps/rubella		
			Polio		
			Chicken Pox		
			Hepatitis A		
			Hepatitis B		
			Meningitis		
			Influenza		
			Other (i.e., HIB)		
			Exemption to immunizations (form required)		

**DO NOT WRITE IN THIS BOX**  
 Review for camp or special activity.  
 Reviewed by: \_\_\_\_\_  
 Date: \_\_\_\_\_  
 Further approval required:  Yes  No  
 Reason: \_\_\_\_\_  
 Approved by: \_\_\_\_\_  
 Date: \_\_\_\_\_

# Part C: Pre-Participation Physical

This part must be completed by certified and licensed physicians (MD, DO), nurse practitioners, or physician assistants.

Full name: \_\_\_\_\_  
 DOB: \_\_\_\_\_

**High-adventure base participants:**  
 Expedition/crew No.: \_\_\_\_\_  
 or staff position: \_\_\_\_\_

**!** You are being asked to certify that this individual has no contraindication for participation inside 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 patient. **!**

**Examiner: Please fill in the following information:**

		Yes	No	Explain							
Medical restrictions to participate											
Yes	No	Allergies or Reactions		Explain		Yes	No	Allergies or Reactions		Explain	
		Medication						Plants			
		Food						Insect bites/stings			

Height (inches): \_\_\_\_\_ Weight (lbs.): \_\_\_\_\_ BMI: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ / \_\_\_\_\_ Pulse: \_\_\_\_\_

	Normal	Abnormal	Explain Abnormalities
Eyes			
Ears/nose/throat			
Lungs			
Heart			
Abdomen			
Genitalia/hernia			
Musculoskeletal			
Neurological			
Other			

## Examiner's Certification

I certify that I have reviewed the health history and examined this person and find no contraindications for participation in a Scouting experience. This participant (with noted restrictions):

True	False	Explain
		Meets height/weight requirements.
		Does not have uncontrolled heart disease, asthma, or hypertension.
		Has not had an orthopedic injury, musculoskeletal problems, or orthopedic surgery in the last six months or possesses a letter of clearance from his or her orthopedic surgeon or treating physician.
		Has no uncontrolled psychiatric disorders.
		Has had no seizures in the last year.
		Does not have poorly controlled diabetes.
		If less than 18 years of age and planning to scuba dive, does not have diabetes, asthma, or seizures.
		<b>For high-adventure participants, I have reviewed with them the important supplemental risk advisory provided.</b>

Examiner's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Provider printed name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP code: \_\_\_\_\_  
 Office phone: \_\_\_\_\_

### Height/Weight Restrictions

If you exceed the maximum weight for height as explained in the following chart and your planned high-adventure activity will take you more than 30 minutes away from an emergency vehicle/accessible roadway, you may not be allowed to participate.

#### Maximum weight for height:

Height (inches)	Max. Weight	Height (inches)	Max. Weight	Height (inches)	Max. Weight	Height (inches)	Max. Weight
60	166	65	195	70	226	75	260
61	172	66	201	71	233	76	267
62	178	67	207	72	239	77	274
63	183	68	214	73	246	78	281
64	189	69	220	74	252	79 and over	295



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**TEN MILE RIVER SCOUT CAMPS**  
**GREATER NEW YORK COUNCILS**

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Individualized Medication Orders  
STANDARD OVER-THE-COUNTER/PRN MEDICATIONS

CAMPER NAME: \_\_\_\_\_ UNIT: \_\_\_\_\_ CAMP: \_\_\_\_\_

CAMPER WEIGHT: \_\_\_\_\_ lbs.      DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_

HEALTHCARE PROVIDER NAME: \_\_\_\_\_ LICENSE #: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

HEALTHCARE PROVIDER SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

I recognize that this is a two-page document

HEALTHCARE PROVIDER STAMP:

**By order of the NYS Department of Health, this form is required for all campers under 18 years of age, and must be accompanied by a completed Annual BSA Health and Medical Record Form.**

The following medications are available in the camp Health Lodge and will be administered at the discretion of the camp Medical Officer, **if approval** is ordered by the Healthcare Provider below.

**Do not send these medications to camp; they are at the Health Lodge**

DRUG NAME	ROUTE <i>circle preferred formulation</i>	DOSAGE	SCHEDULE	PROVIDER ORDER <i>check one</i>	COMMENTS
BENADRYL (25 to 50 mg)	PO (elixir, chewable tabs, pills)	Per label instructions by age/weight	Q 6 hr prn for allergic reaction (hives, insect bite)	<input type="checkbox"/> YES <input type="checkbox"/> NO	
CEPACOL	PO (lozenges)	Per label instructions by age/weight	Q 2 hr for sore throat (no > 4 doses in 24 hr and no fever)	<input type="checkbox"/> YES <input type="checkbox"/> NO	
CHILDREN'S DIMETAPP COLD & ALLERGY	PO (elixir, tabs)	Per label instructions by age/weight	Q 6-8 hr prn for nasal congestion/drainage	<input type="checkbox"/> YES <input type="checkbox"/> NO	
IBUPROFEN (200 to 400 mg)	PO (chewable tabs, suspension, tabs)	Per label instructions by age/weight	Q 6 hr prn for pain or fever > _____ °F	<input type="checkbox"/> YES <input type="checkbox"/> NO	
MYLANTA	PO (chewable tabs)	Per label instructions by age/weight	TID prn for stomach upset	<input type="checkbox"/> YES <input type="checkbox"/> NO	
CHILDREN'S PEPTO BISMOL	PO (liquid, chewable tabs)	Per label instructions by age/weight	TID prn for stomach upset (no > 4 doses in 24 hr)	<input type="checkbox"/> YES <input type="checkbox"/> NO	
ROBITUSSIN	PO (syrup)	Per label instructions by age/weight	Q 4 hr prn for cough	<input type="checkbox"/> YES <input type="checkbox"/> NO	

**Individualized Medication Orders**  
**STANDARD OVER-THE-COUNTER/PRN MEDICATIONS**

CAMPER NAME: \_\_\_\_\_ UNIT: \_\_\_\_\_ CAMP: \_\_\_\_\_

DRUG NAME	ROUTE <i>circle preferred formulation</i>	DOSAGE	SCHEDULE	PROVIDER ORDER <i>check one</i>	COMMENTS
TYLENOL	PO (chewable tabs, elixir, tabs)	Per label instructions by age/weight	Q 4 hr prn for pain or fever > _____ °F	<input type="checkbox"/> YES <input type="checkbox"/> NO	
CALADRYL	Topical	Per label instructions by age/weight	as directed for itches, bites, skin irritations, rashes	<input type="checkbox"/> YES <input type="checkbox"/> NO	
BACITRACIN OINTMENT	Topical	Per label instructions by age/weight	as directed for minor cuts and abrasions	<input type="checkbox"/> YES <input type="checkbox"/> NO	
TINACTIN (or equivalent)	Topical (liquid, powder)	Per label instructions by age/weight	as directed for athlete's foot, jock itch, fungal rash	<input type="checkbox"/> YES <input type="checkbox"/> NO	

The medications above are the **only medications** that are available in the camp Health Lodge. If additional over-the-counter medications are required, the camper's parent/guardian must make arrangements to procure and send these medications to camp with the camper's unit leader. The Healthcare Provider should list any such medications below.

**SELF-PROVIDED OVER-THE-COUNTER/PRN MEDICATIONS**

*please strike-out this section if not needed*

				<input type="checkbox"/> YES <input type="checkbox"/> NO	
				<input type="checkbox"/> YES <input type="checkbox"/> NO	
				<input type="checkbox"/> YES <input type="checkbox"/> NO	