Denver Area Council, B.S.A.

Personal Health and Medical Record—Class 1 and Class 3

Instructions: This form is two sided. By completing only the front side, this form qualifies as a Class 1 medical history. A Class 1 medical history is a brief health history that does not require a physician's signature. A Class 1 medical history is required for all youth and adults to attend any Denver Area Council event. By completing the front *AND* the back, this form qualifies as a Class 3 medical record. A Class 3 medical record is a complete health history that requires a physician's signature indicating that the youth or adult is fit to attend the event. A Class 3 medical record is required for all youth and adults staying 72 hours or more at a Denver Area Council event. Youth and adults without a completed medical form will not be allowed to participate and sent home. Please make copies of this form, as it will not be returned to you at the end of the event.

I. Personal and Emergency Contact Information

Name: _____ Date of Birth:_____ Age:_____ Sex:_____
Last Name First Name Middle Initial

Address: _____ City / State:_____ ZIP:_____

Name of Parent / Guardian or Spouse: _____ Phone #:_____

Place of Employment: _____ Phone #:_____

If person named above is not available in the event of an emergency, please contact:

Name: _____ Relationship: _____ Phone #:_____

Name: _____ Relationship: _____ Phone #:_____

Persons authorized to take youth from the event (include address and phone):

_____

_____

*Persons **NOT** authorized to take youth from the event (include address and phone):*

_____

_____

II. Health History / Information

Name of Primary Physician: _____

Primary Physician's Phone #: _____

Primary Physician's Address: _____

City / State: _____ ZIP: _____

Name of Dentist / Orthodontist: _____

Dentist / Orthodontist Phone #: _____

Medical Insurance Provider: _____

Carrier's Name: _____

Policy or Group #:_____ Medicaid ID #: _____

Medications taken within last 30 days: _____

_____

_____

_____

Medications to be continued at event (with dosage): _____

_____

_____

_____

Other Special Instructions related to Medications: _____

_____

_____

Check all items of concern or that apply, past or present, to your health history.

[ ] Frequent Ear Infections
[ ] ADD/ADHD
[ ] Mononucleosis
[ ] Heart Defect/Disease
[ ] Mumps
[ ] Asthma
[ ] Kidney Disease
[ ] German Measles
[ ] Hay Fever
[ ] Hypertension
[ ] Convulsions/Epilepsy
[ ] Drug Allergies
[ ] Diabetes
[ ] Bleeding/Clotting Disorders
[ ] Chicken Pox
[ ] Insect Stings
[ ] Measles
[ ] Other Allergies (list below)

Explain all items checked above: _____

_____

_____

_____

Problems or diseases not mentioned above: _____

_____

_____

Recurring illness or disability: _____

_____

_____

Operations or serious injuries (dates): _____

_____

_____

III. Parent / Minor Signatures

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted.

Emergency Authorization: I hereby give permission to the medical personnel selected by the camp director to order x-rays, routine tests and treatment for me/or my child, and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for me/or my child as named above. Permission is also given to transport me/or my child for medical assistance. This form may be photocopied for use at camp. I understand that I am responsible for payment of all medical treatments received.

I also give permission for my child to go on trips away from camp premises, and to participate in all camp activities.

***** Signature of parent or Guardian (or participant if over 18):** _____ Date: _____

Signature of Witness: _____ Date: _____

***** Signature of Minor:** _____ Date: _____

******* ***YOU MUST HAVE THE ABOVE SIGNATURES TO ATTEND THE EVENT!!*** *******

NAME: _____ TROOP: _____ CAMPSITE: _____

IV. Immunization History

REQUIRED IMMUNIZATIONS MUST BE DETERMINED LOCALLY. Please record the date (month and year) of basic immunizations and most recent booster doses. If disease has occurred, indicate with a "D" and give date in last booster section.

VACCINES	DATES OF BASIC IMMUNIZATIONS	DATES OF LAST BOOSTER
Diphtheria	_____	_____
Pertussis (whooping cough)	_____	_____
Tetanus	_____	_____
Oral Polio (Sabin) TOPV	_____	_____
Injectable polio (Salk)	_____	_____
Measles (hard measles, red measles)	_____	_____
Mumps	_____	_____
Rubella (German measles, 3-day measles)	_____	_____
Chicken Pox	_____	_____

V. Medical Examination By Licensed Physician

Instructions to Licensed Health-Care Practitioner:

This applicant will be participating in a strenuous activity that could include one or more of the following conditions: Athletic competition, adventure challenge or wilderness expedition (afoot or afloat) that may include high altitude extreme weather conditions, cold water, exposure, fatigue and/or remote conditions where readily available medical care cannot be assured.

Review complete medical history (part II on reverse side) furnished by applicant before beginning examination.

Review Immunization history (part IV above) and assure that immunizations are complete and up-to-date.

Height: _____ Weight: _____ BP: _____ Pulse: _____

Check box if normal; circle if abnormal and give details below:

[ ] Growth, development	[ ] Skin, glands, hair	[ ] Head, neck, thyroid	[ ] Eyes, ears, nose
[ ] Teeth, tonsils	[ ] Respiratory	[ ] Cardiovascular	[ ] Abdomen, hernia
[ ] Genitourinary	[ ] Skeletomuscular	[ ] Neuropsychiatric	[ ] Other (specify)

Details: _____

_____

_____

I have examined this individual and found him/her to be in satisfactory condition with the following exceptions: _____

_____

In my opinion, this individual IS / IS NOT (circle one) able to participate in all activities.

Recommendations and/or restrictions: _____

Treatments to continue at event: _____

Dietary Restrictions: _____

Medications (include dosage) to continue at event: _____

Licensed Physician's Signature: _____ Date: _____

Date Examined: _____ Form Completed By (initial): _____

mar(2/20/01)