Treasure Valley Scout Reservation Medical Form

For All Boy Scout, Cub Scout & Venture Activities

Mohegan Council, Boy Scouts of America

Meets All BSA Health and Medical Record Class 3 Requirements

This Health and Medical Record is required for participation in resident camp at Treasure Valley Scout Reservation. Each participant at Treasure Valley is subject to medical recheck. Treasure Valley recognizes the right to a Scout not to have immunizations etc. because of religious beliefs; however, a statement signed by the parents is required, indicating that the Scout is free from contagious disease and is able to physically tolerate camping at Treasure Valley. Write to Mohegan Council, 19 Harvard Street, Worcester, MA 01609 for a copy of the statement required.

IMPORTANT – The participant must provide a CURRENT health history, a CURRENT immunization record, and a report of a physical examination conducted during the preceding 24 months (CMR 430.151 (A-2). **Adults 40 years of age or over must show evidence of physical exam within the past 12 months** (BSA National Standards).

DIRECTIONS –

1. **Parents/guardians must complete pages 1,2,4,5 & 6**
2. This form is to be renewed yearly by parent/guardian
3. Physician's Office completes & verifies immunizations history and SIGNS WHERE INDICATED – OR – attached signed report of physical examination conducted during the preceding 24 months **(for persons 40 years of age or over, within the preceding 12 months).**
4. **Participant (or parent / guardian of participant under 18 years of age) SIGNS in all areas indicated.**
5. DO NOT mail this form anywhere!!! Bring it to camp and to the medical recheck.

PER STATE AND BSA REGULATIONS:

FAILURE TO PROPERLY COMPLETE THIS FORM WILL RESULT IN THE INDIVIDUAL NOT BEING ADMITTED TO CAMP.

IDENTIFYING INFORMATION – To be completed by Parent or Participants 18 years of age or older.

NAME: ______________________________ **UNIT #** ____ **DOB:** _________ **AGE:** ___ **SEX** ___

ADDRESS: ______________________________ CITY: ______________ STATE: ____ ZIP: _______

IN THE EVENT OF EMERGENCY, PLEASE NOTIFY (give full names, area codes, and telephone numbers)

Mother: ____________________ Home Tel: __________ Work Tel: __________ Mobile: __________

Father: ____________________ Home Tel: __________ Work Tel: __________ Mobile: __________

☐ Please notify both parents. In the event that neither parent can be reached, or for adult participant, call:

Name: ____________________ Relationship: _______ Home Tel: __________ Work Tel: __________

Parents' vacation address, if any: ______________________________ Telephone: ______________

Insurance Co. or HMO: ____________________________ Policy #: ______________

Insurance Co. or HMO address: ______________________ City and State: _____________ Zip: _____

Physician's Name: ____________________ City & State: ______________ Tel: ______________

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Please fill out this page completely

EMERGENCY INFORMATION / HEALTH HISTORY / INCLUDING ALL ALLERGIES

– To be completed by Parent or Participants 18 years of age or older.

ARE THE PARENT / PARTICIPANT AWARE OF ANY CURRENT HEALTH PROBLEMS? _____No _____ Yes

Details: ____

IS THE PARTICIPANT UNDER MEDICAL CARE FOR ANY REASON? _____No _____ Yes

Details: ____

HAS THERE BEEN ANY SURGERY, INJURY, ILLNESS, ALLERGY, OR CHANGE IN HEALTH STATUS SINCE LAST COMPLETE PHYSICAL EXAMINATION? _____No _____ Yes Detail: ______________________________

IS THERE DISEASE OF, OR PAST OR PRESENT HISTORY OF:

Serious illness	___No	___ Yes	Bridge	___No	___ Yes	Sugar	___No	___ Yes
Serious injury	___No	___ Yes	Chest, Lungs	___No	___ Yes	Infection	___No	___ Yes
Deformity	___No	___ Yes	Heart	___No	___ Yes	Bed wetting	___No	___ Yes
Surgery	___No	___ Yes	Murmur	___No	___ Yes	Menstrual	___No	___ Yes
Skin, Glands	___No	___ Yes	Rheumatic fever	___No	___ Yes	Hernia	___No	___ Yes
Ears, Eyes	___No	___ Yes	Stomach, Bowels	___No	___ Yes	Back, Limbs	___No	___ Yes
Nose, Sinus	___No	___ Yes	Appendicitis	___No	___ Yes	Sleepwalking	___No	___ Yes
Teeth, Tonsils	___No	___ Yes	Kidneys, Urine	___No	___ Yes	Nervousness	___No	___ Yes
Dentures	___No	___ Yes	Albumin	___No	___ Yes	Tuberculosis	___No	___ Yes

Details: ____

PARTICIPANT HAS OR IS SUBJECT TO THE FOLLOWING (give details for any checked):

_____ **Allergy to a medicine, food, plant or insect toxin:** ______________________________

_____ **Any condition that may require special care, medication, or diet:** ____________________

_____ **ADHD (Attention Deficit Hyperactivity Disorder)**

_____ **Asthma** _____ **Contact Lenses** _____ **Dentures** _____ **Fainting Spells**

_____ **Bleeding** _____ **Convulsions** _____ **Diabetes** _____ **Heart Trouble**

Details: ____

MEDICATIONS – To be completed by Parent or Participants 18 years of age or older.

IF PARTICIPANT IS UNDER 18 YEARS OF AGE:

Is the participant **bringing any medications (prescriptions or over the counter)** to camp? __ Yes __ No. If yes, please complete the Authorization to Administer Medication to a Camper or Staff Member less than 18 years of age section on page 4 & 5 of this packet.

IF PARTICIPANT IS 18 YEARS OF AGE OR OLDER:

Is the participant bringing any medications to camp? _____ Yes _____ No

If yes, list medications: ____

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This page to be filled out Physician's office & signed where indicated

IMMUNIZATIONS – Per Massachusetts State regulations, Must be varified by Physician's Office.

Has the participant had chicken pox? ___ No ___ Yes

Has the participant had chicken pox vaccine? ___ No ___ Yes

FOR CAMPERS AND STAFF UNDER 18 YEARS OLD – (please indicate dates on lines below)

MMR Dose 1 ______ Dose 2 ______

Polio Dose 1 ______ Dose 2 ______ Dose 3 ______ Dose 4 ______

DTP Dose 1 ______ Dose 2 ______ Dose 3 ______ Dose 4 ______

Hepatitis B required for all children born on or after January 1, 1992. Dose 1 ______

FOR CAMPERS AND STAFF 18 YEARS OLD AND OLDER – (please indicate dates on lines below)

Measles: Born before 1957 ______, or Laboratory evidence of immunity ______, Dose 1 ______ Dose 2 ______

Mumps: Born before 1957 ______, or Laboratory evidence of immunity ______, Dose 1 ______

Rubella: Laboratory evidence of immunity ______, Dose 1 ______

Diphtheria and Tetanus Toxaids*: Polio Dose 1 ______ Dose 2 ______ Dose 3 ______

*A booster dose of tetanus, diphtheria, adult type toxaid (Td) is required if more than 10 years have passed since the last one.

Physician's Office Verification: ______________________________ Date: __________

PHYSICAL EXAMINATION – To be completed by LICENSED HEALTH CARE PROVIDER

Height ________ Weight ________ B.P. ______/_______ Pulse ___________

Vision: Normal _______ Glasses ________ Contacts __________

Hearing: Normal _______ Abnormal ______ Hearing Aide ______

CHECK BOX IF NORMAL / CIRCLE IF ABNORMAL AND GIVE DETAILS BELOW:

_____ Growth, Development _____ Teeth, Tonsils _____ Genitourinary _____ Skin, Glands, Hair

_____ Respiratory _____ Skeletomuscular _____ Head, Neck, Thyroid _____ Cardiovascular

_____ Neuropsychiatric _____ Eyes, Ears, Nose _____ Abdomen, Hernia, Rings _____ Other (specify)

COMMENTS: ____

APPROVED FOR PARTICIPATION IN:

___ Hiking and camping _____ Water activities _____ Competitive sports _____ All activities

Specify exceptions: ____

Recommendations (explain any restrictions OR limitations): ______________________________

Physician's Verification: ______________________________ Date: __________

Health Care Practitioner Licensed to Perform Physical Examination's Information:

**Telephone: ______________________ Address: ______________________________

Treasure Valley Scout Reservation Medical Form (page 4)

AUTHORIZATION TO ADMINISTER MEDICATION TO A CAMPER OR STAFF UNDER 18 YEARS OF AGE – To be completed by parent or legal guardian.

Parents/guardians requesting medication administration to their child from camp staff shall provide the camp heath staff with appropriate written authorization(s) and the medication before any medications are administered. Medications must be in the original container and labeled with the child's name, name of medication, directions for medication's administration, and date of the prescription. All unused medication will be destroyed within one week following the camper's departure at the end of camp.

Authorized Prescriber's Order (Physician, Dentist, Physician Assistant, Advanced Practice Registered Nurse):
Name of Child___________________________________Date of Birth____/____/____ Date____/____/2008
Medication Name____ Controlled Drugs yes___No____
Dosage_______________________ Route_________ Time of Administration_________________________
Specific Instructions for Medication Administration____
Medication Administration: Start Date_____/_____/_____ Stop Date_____/_____/_____
Relevant Side Effects of Medication____
Plan of Management for SideEffects____
Known Food or Drug Allergies: Yes___No___ Reactions to? Yes___No___ Interactions with? Yes___No___
If "yes" to any of the above, please explain____
***This medication is an emergency medication and NOT a controlled substance, and the camper is authorized to**
Carry and self-administer the above prescribed medication: Yes____No____
Prescriber's Name____
Prescriber's Address____
Phone Number (_____)______________ Fax Number (_____)_____________
Prescriber's Signature____ Use for Prescriber's Stamp

____

Parent/Guardian Authorization:
I request that medication be administered to my child as described and directed above, and agree to Provide the camp with the medication's in a quantity Appropriate for my child's stay at camp.
if applicable, I authorize my child to carry and self-administer the above-prescribed **emergency** medication.
Yes____No____
Parent/guardian Signature___________________________________Relationship to Child______________Date____/____/____

____

Camper Agreement (only for emergency medications to be self-carried and administered):
I have been trained and understand how and when to use my medications. I accept the responsibility to Carry my medication with me at all times, to not share it with anyone else, and to inform the camp health Staff when I have used it.
Camper Signature____
Signature of Camp Personnel receiving Written Authorization and Medication_________________________________
Title/Position____Date____/____/___

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AUTHORIZATION TO ADMINISTER OVER THE COUNTER MEDICATION TO A CAMPER OR STAFF UNDER 18 YEARS OF AGE – To be completed by parent or legal guardian.

Over the counter Medication Description Form

This summer we are asking all campers who will be taking any OTC medication's while at camp to complete an **OTC Medication Description Form.** Please enclose all medications (enough for the week your scout is at camp) in a sealed bag with the scouts name, campsite & troop number on it along with the completed Medication Description Form and send this with your scout to camp to be given to the camp medical officer at medical check in.

Please note; All over the counter medications are to be in their original packaging not expired, or we will be unable to administer that medication to your child.

The information on this form is correct and complete. I hereby give my permission for Treasure Valley Scout Reservation medical staff to administer the medication as directed.

____________________________ Relation to camper __________ Date___/____/ 2008
Parent/guardian signature

Camper's name: __________________________ **troop number** _________

Allergies: ____

Medication name	given at	dose	special instructions
	Breakfast		
	Lunch		
	Supper		
	Bedtime		

Any special instructions:

____

____

____

____

____

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Unit leaders & parents/guardians please sign were indicated

PARENTAL STATEMENT AND TALENT RELEASE – Parent or Participant over 18 please read and sign.

I, the undersigned, have read and understood this entire form. The information provided herein is accurate and complete. The person described herein has permission for the full participation in the BSA programs, subject to any limitations noted herein. In the event of illness or accident in the course of such activity, I hereby request that measures be instituted without delay as the judgment of medical personnel dictates. These measures may include but are not limited to treatment in camp, transportation to and out–of camp medical facility, treatment at such facility, and any outside physician, hospital, or treatment facility to release and exchange any and all information connected with treatment.

I hereby assign and grant to the Boy Scouts of America the right and permission to use and publish any photographs/film/video tapes/electronic representations and/or sound recordings made of me (or my child) by the Boy Scouts of America, and I hereby release the Boy Scouts of America from any and all liability from such use and publication.

I hereby authorize the reproduction, sale, copyright, exhibit, broadcast, electronic storage and/or distribution of said photographs/film/video tapes/electronic representations and/or sound recordings without limitation at the discretion of the Boy Scouts of America and I specifically waive any right to any compensation I (or my child) may have for any of the foregoing.

Note: Once submitted, this form becomes the property of Treasure Valley Scout Reservation. Parents, participants, and / or Troop Leaders who need extra copies are urged to make them prior to coming to camp.

Participant's Signature (if 18 or older)**:** ______________________________________ **Date:** __________

Parent's Signature (if participant is under 18)**:** _________________________________ **Date:** __________

*****TROOP LEADER AND CAMP SCREENING*****

Reviewed by Unit Leader (print) ______________________________________ Position ________

Signature ____ Date / / 2008

Screened at Camp by ____________________________ OK'd _______________________ Date ________

Notes: ____

Screened at Camp by ____________________________ OK'd _______________________ Date ________

Notes: ____

Additional Comments: ____