

PERSONAL HEALTH AND MEDICAL RECORD FORM - CLASS 3

1. Identification:

Age: _____ Sex: _____ **Date of Birth:** Mo. ____ Day: ____ Year: ____
 Last Name: _____ First Name _____ MI. ____
 Address: _____
 City: _____ State: _____ Zip: _____
 Insurance Co.: _____ Policy # _____

IN AN EMERGENCY NOTIFY.

Name: _____ Relationship: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Home Phone: () _____ Work: () _____
 Personal Physician: _____
 Office Phone: () _____ Home: () _____

Massachusetts Immunization Certification

The following section must be reviewed by the examining physician and signed before entry into camp.

105 CMR 430.155. Required Immunizations:

Written documentation of Immunization or alternative proof of immunity shall be required for all campers and staff members (paid or volunteer) at recreational camps for children as follows:

a. For Campers and Staff Under 18 Years Old

(1.) Measles, Mumps and Rubella (MMR) Vaccine: At least one dose of MMR Vaccine(s) must be administered at/or after 12 months of age or there must be proof of laboratory evidence of immunity.

(2.) Polio Vaccine: at least 3 doses of either trivalent oral polio vaccine (OVP) or enhanced potency injectable Polio vaccine (e-ip) are required.

(3.) Diphtheria, Tetanus toxoids & Pertussis Vaccine: At least 4 doses of DTP/DT/Td are required. (the Pertussis component is not given to anyone 7 years of age or older). A booster dose of tetanus/diphtheria, adult type toxoid (Td) is required if more than 10 years has elapsed since last dose.

***(4.) Measles Vaccine (effective January 1, 1992):** All campers and staff 12 through 17 years of age must have two doses of live measles vaccine administered at, or after, 12 months of age (at least one month apart) or proof specified in 105 CMR 430.155 (A)(1).

b. For Campers and Staff 18 years of age or older:

***(1) Measles Vaccine:** Unless born before 1957, two doses of live measles containing vaccine administered at/or after 12 months of age (at least one month apart) are required, or proof of laboratory evidence of immunity to measles.

***(2) Mumps Vaccine:** Unless born before 1957, at least one dose of mumps vaccine administered at/or after 12 months of age or proof of laboratory evidence of immunity to mumps.

***(3) Rubella Vaccine:** At least one dose of Rubella Vaccine administered at/or after 12 months of age or proof of laboratory evidence of immunity to Rubella.

***(4) Diphtheria and Tetanus Toxoids:** At least 3 doses of DT/Td are required. A booster dose of tetanus/diphtheria, adult type toxoid (Td) is required if more than 10 years have elapsed since the last dose.

*** Laboratory evidence of immunity to the disease indicated may be substituted for the requirement.**

Health Care Provider Certification

I hereby certify that I have reviewed the above standards and the medical records of this applicant. I find that this applicant is in compliance with the standards. My signature is on this form.

AUTHORIZED PICK-UP TO SAFEGUARD CAMPERS

To Be Completed for all campers

Camper name: _____

Pack or Troop # _____ Campsite: _____
 (circle one)

The following adult(s), (21 years old or older) are authorized to pick up my son, if necessary (other than unit leaders):

Name: _____
 Phone: _____
 Relationship: _____

Name: _____
 Phone: _____
 Relationship: _____

3. Parental Statement:

Has it ever been necessary to restrict applicant's activities for medical reasons No Yes

Does applicant take regular medicine or have special care ?
 No Yes

If YES, list **medications and or restrictions below.** For medications, give name of drug dose of drug & how often to be administered. (Time will be determined by the Health Officer.

To the best of my knowledge, the information in sections 1, 2, 3, 4 and 6 is accurate and complete. I request physician to examine applicant, to give needed immunization, and to furnish requested **information to other agencies** as needed. I give my permission for full participation in BSA programs, subject to limitations noted herein. In the event of illness or accident in the course of such activity, I request that measures be instituted without delay as judgment of medical personnel dictates. I give my permission for the Health officer or designated personnel to administer the above listed medications.

Parent or Guardian X _____
 (must sign if applicant is under 18)

Applicant Signature X _____

Date signed: _____

FOR THOSE ATTENDING PHILMONT OR NATIONAL HIGH ADVENTURE BASES:

The minimum age for all participants in 13 by January 1 of the year of participation. No exceptions.

Trail food is, by necessity, a high carbohydrate, high caloric diet. It is high in wheat, milk products, sugar, corn syrup, and artificial coloring/flavoring. Dinner meals contain meat. If these food products cause a problem in your diet, you need to bring appropriate substitutions with you and so advise base personnel.

Note: Physicians representing high adventure bases reserve the right to deny access to the trails or other program activity on the basis of a medical evaluation performed at the base after arrival.

This form has been revised to comply with the laws of the Commonwealth of Massachusetts
 Great Trails Council - BSA , 88 Old Windsor Rd.
 Dalton, MA 01226 (413) 684-3542

4. Medical History:

Parent/Guardian (or applicant if over 18): Fill in section 1, 2, 3, and 4 BEFORE seeing physician. Check immunizations to be given at this time. Be sure to include any emergency information and restrictions or special care that should be observed. Especially be sure to record any injuries, illnesses, surgery, or significant changes in condition of health of applicant since last complete examination.

Date of most recent complete physical examination

(month and year): _____ 19 _____
 * Are you aware of any current health problems'? No Yes
 * Now under medical care, or taking medicines' ? No Yes
 * Has there been any surgery, injury, illness, allergy, or change in health status since last complete physical examination ?
No Yes

Give dates and FULL details below for any "yes" answers:

IS THERE DISEASE, OR PAST/PRESENT HISTORY OF:

	NO	YES	YEAR	DETAILS
Serious Illness	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Serious Injury	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Deformity	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Skin, glands	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Ears, eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Nose, sinus	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Teeth, tonsils	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Dentures	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Bridge	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Chest, lungs	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Heart	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Murmur	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Stomach, bowels	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Appendicitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Kidneys, or urine	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Albumin	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Sugar	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Infection	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Bed-wetting	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Menstrual problem	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hernia (rupture)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Back, limbs, joint	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Sleepwalking	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Nervous condition	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Other (explain)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

2. Emergency Medical Information:

Has, or is subject to, (check and give details):

- Allergy to a medicine, food, plant, animal, or insect toxin.
- Any condition that may require special care, medication, or diet.
- Asthma Convulsions Heart trouble Contact tenses
- Diabetes Fainting spells Bleeding disorders Dentures

EXPLAIN: _____

IMMUNIZATIONS: If disease, put "D" and year:

	Last year given		Last year given
Tetanus	_____	Diphtheria	_____
Pertussis	_____	Measles	_____
Mumps	_____	Rubella	_____
Polio	_____	Chicken Pox	_____

Please Read Massachusetts Immunization Requirements on reverse Side.
Date of Last Tetanus Shot Required

5. Health Examination:

To the Physician:

The applicant will be participating in a strenuous activity that will 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 condition, cold water, exposure, fatigue and/or remote conditions where readily available medical care cannot be assured.

- * Please insist applicant furnish complete medical history (4) before exam.
- * Review immunizations; for youth (under 18) tetanus and diphtheria toxoids, measles, mumps, and rubella vaccines, and trivalent oral polio vaccine are required; adults are required to have tetanus booster within 10 years.
- * After completing this section (5), summarize any restrictions and/or recommendations in sections 2 and 6, and sign in section 6.

	VISION	HEARING
Date: _____	Normal _____	Normal _____
Ht. _____ wt. _____	Glasses _____	Abnormal _____
BP. ____ / ____ Pulse _____	Contacts _____	

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: _____

***Laboratory:** Urinalysis (Dip stick) Albumin _____ Sugar _____
 *if needed

6. Physician's Evaluation and advice:

Approved for participation in:

- Hiking and camping Water activities
- Competitive sports All activities

Specify exceptions: _____

Recommendations: (explain any restrictions OR limitations): _____

Physician Signature:

X _____
 (Licensed Health-Care practitioner)

PLEASE TYPE, OR PRINT
 Name _____
 Unit _____
Note Keep original form for your personal record. Make reproductions for agency use. Be sure information and signatures are legible on reproduced copies. This form may be reproduced and carried with you for emergency identification and care.