

NEW MEDICAL FORM ... AGAIN! (But simpler)

Effective March 1, 2014, National has rolled out a new simplified annual health and medical record. Input on this form was obtained from the medical community, adults, and unit leaders. Key components of the new form are:

- **Part A: Informed Consent, Release Agreement, and Authorization**
Will contain no medical information and will be shorter by one page.
- **Part B: General Information/Health History**
Will include only the most important information needed.
- **Part C: Pre-Participation Physical**
Will be reduced to one page with expanded sections for allergy explanation.
- **Part D: Supplemental Risk Advisory**
Will be shortened and will be location specific.

A Webinar will be held on April 04, 2014 at 1 PM CENTRAL TIME-
Log on to <http://www.livestream.com/bsanationalcouncil>

BSA's Health Form page ([here](#)) has been updated to make it easier to find the exact form you need. But here's an overview ...

- For weekend camping trips less than 72 hours, Cub Scout Day Camp, Webelos Woods, Camporall, Family Camping and local tours where a physical is not needed:
[Download Parts A & B here](#)
- For camping trips more than 72 hours, resident camps (summer or winter) where a pre-participation physical is needed:
[Download Parts A, B & C here](#)
- For high-adventure trips like Sea Base, Northern Tier, Philmont and Summit, visit the Health Form page [here](#) for Part D and other Risk forms.

MAKE IT EASY ON YOURSELF

These PDF forms can be filled out on your computer, printed (even emailed?) and then saved for future updates or reprints. This removes handwriting errors and is the requested way to submit all medical forms.

Obviously Part C that requires a physical will have to be submitted by hand or scanned. But always submit a copy and keep the original.

Part A: Informed Consent, Release Agreement, and Authorization

Full name: _____ High-adventure base participants: _____
 Expedition/crew No.: _____
 or staff position: _____

DOB: _____

Informed Consent, Release Agreement, and Authorization
 I understand that my participation in this activity involves certain risks of personal injury, including death, due to the physical, mental, and emotional challenges in the wilderness. I understand that these risks are inherent in the activity and that I am assuming the risk of injury or death. I understand that I am releasing the BSA, National Council, and all other organizations associated with any program or activity from any and all liability, including death, due to the physical, mental, and emotional challenges in the wilderness. I understand that I am releasing the BSA, National Council, and all other organizations associated with any program or activity from any and all liability, including death, due to the physical, mental, and emotional challenges in the wilderness. I understand that I am releasing the BSA, National Council, and all other organizations associated with any program or activity from any and all liability, including death, due to the physical, mental, and emotional challenges in the wilderness.

I understand that, if any information I 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 in a BSA National Council activity, I understand that I am releasing the BSA, National Council, and all other organizations associated with any program or activity from any and all liability, including death, due to the physical, mental, and emotional challenges in the wilderness. I understand that I am releasing the BSA, National Council, and all other organizations associated with any program or activity from any and all liability, including death, due to the physical, mental, and emotional challenges in the wilderness.

Participant signature: _____ Date: _____
 Participant signature for youth: _____ Date: _____
 (If participant is under the age of 18)

Second participant/guardian signature for youth: _____ Date: _____
 (If required, for example, California)

Complete this section for youth participants only:
 Adults Authorized to Take Youth to and From Events:
 Name: _____ Telephone: _____
 Name: _____ Telephone: _____

Adults NOT Authorized to Take Youth To and From Events:
 Name: _____ Telephone: _____

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Part B: General Information/Health History

Full name: _____ High-adventure base participants: _____
 Expedition/crew No.: _____
 or staff position: _____

DOB: _____

Age: _____ Gender: _____ Height (inches): _____ Height (ft.): _____

Address: _____ City: _____ State: _____ ZIP code: _____ Telephone: _____

Unit Number: _____ Mobile phone: _____ Cell No.: _____

Health/accident insurance Company: _____ Policy No.: _____

Please attach a photocopy of both sides of the insurance card. If you do not have health insurance, enter "none" above.

In case of emergency, notify the person below:
 Name: _____ Relationship: _____
 Address: _____ Home phone: _____ Other phone: _____
 Alternate contact name: _____ Work phone: _____

Health History
 Do you currently have or have you ever had any of the following?

Yes	No	Condition	Last MRI percentage and date	Explain
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis		
<input type="checkbox"/>	<input type="checkbox"/>	Hypertension, High blood pressure		
<input type="checkbox"/>	<input type="checkbox"/>	Adult or congenital heart disease/heart attack/heart palpitations/heart irregularities/heart disease (only heart surgery or procedure, report date)		
<input type="checkbox"/>	<input type="checkbox"/>	Stroke (history of stroke, TIA, or transient ischemic attack)		
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes		
<input type="checkbox"/>	<input type="checkbox"/>	Lung/respiratory disease		
<input type="checkbox"/>	<input type="checkbox"/>	ADHD		
<input type="checkbox"/>	<input type="checkbox"/>	Chronic obstructive pulmonary disease		
<input type="checkbox"/>	<input type="checkbox"/>	Non-infectious connective tissue or bone disease		
<input type="checkbox"/>	<input type="checkbox"/>	Head injury/concussion		
<input type="checkbox"/>	<input type="checkbox"/>	Allergic diseases		
<input type="checkbox"/>	<input type="checkbox"/>	Progressive neurological or emotional difficulties		
<input type="checkbox"/>	<input type="checkbox"/>	Behavioral/neurological disorders		
<input type="checkbox"/>	<input type="checkbox"/>	Blood disorders/bleeding disorders		
<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells and dizziness		
<input type="checkbox"/>	<input type="checkbox"/>	Seizure disorders		
<input type="checkbox"/>	<input type="checkbox"/>	Seizures	Last seizure date	
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal/irregular digestive problems		
<input type="checkbox"/>	<input type="checkbox"/>	Recent disease		
<input type="checkbox"/>	<input type="checkbox"/>	Iron-deficiency anemia		
<input type="checkbox"/>	<input type="checkbox"/>	Obstructive sleep apnea/sleep disorders	CPAP: Yes <input type="checkbox"/> No <input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Use of any organic and inorganic substances		Last organic date
<input type="checkbox"/>	<input type="checkbox"/>	List any other medical conditions not covered above		

Yes No Non-prescription medication administration is authorized with these exceptions.

Additional copies of the above medications is approved for youth by: _____

Participant signature: _____ MDD/NE 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.

Allergies/Medications
 Do you currently have or have you ever had any of the following?

Yes	No	Allergies or Reactions	Explain
<input type="checkbox"/>	<input type="checkbox"/>	Food	
<input type="checkbox"/>	<input type="checkbox"/>	Insect	
<input type="checkbox"/>	<input type="checkbox"/>	Medications/Drugs	
<input type="checkbox"/>	<input type="checkbox"/>	Latex	
<input type="checkbox"/>	<input type="checkbox"/>	Other	

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.

Participant signature: _____ MDD/NE or PA signature (if your state requires signature)

Immunization
 The following information is recommended by the BSA. National immunization is required and must have been received within the last 10 years. If you meet the criteria, check the boxes below and be sure to date. If immunized, check box and provide the year received.

Yes	No	Last Received	Immunization	Category	Explain
<input type="checkbox"/>	<input type="checkbox"/>		Diphtheria		
<input type="checkbox"/>	<input type="checkbox"/>		Tetanus		
<input type="checkbox"/>	<input type="checkbox"/>		Polio		
<input type="checkbox"/>	<input type="checkbox"/>		Measles/mumps/rubella		
<input type="checkbox"/>	<input type="checkbox"/>		Whooping cough		
<input type="checkbox"/>	<input type="checkbox"/>		Hepatitis A		
<input type="checkbox"/>	<input type="checkbox"/>		Hepatitis B		
<input type="checkbox"/>	<input type="checkbox"/>		Meningitis		
<input type="checkbox"/>	<input type="checkbox"/>		Philaenia		
<input type="checkbox"/>	<input type="checkbox"/>		Other (List)		
<input type="checkbox"/>	<input type="checkbox"/>		Complete all immunizations (none required)		

Please list any additional information about your medical history:

DO NOT WRITE IN THIS BOX

Parent/guardian signature: _____ Date: _____
 Further approval required: Yes No

Participant signature: _____ Date: _____

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Part B: General Information/Health History

Full name: _____ High-adventure base participants: _____
 Expedition/crew No.: _____
 or staff position: _____

DOB: _____

Allergies/Medications
 Do you currently have or have you ever had any of the following?

Yes	No	Allergies or Reactions	Explain
<input type="checkbox"/>	<input type="checkbox"/>	Food	
<input type="checkbox"/>	<input type="checkbox"/>	Insect	
<input type="checkbox"/>	<input type="checkbox"/>	Medications/Drugs	
<input type="checkbox"/>	<input type="checkbox"/>	Latex	
<input type="checkbox"/>	<input type="checkbox"/>	Other	

List all medications currently used, including any over-the-counter medications.
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<input type="checkbox"/>	<input type="checkbox"/>		Tetanus		
<input type="checkbox"/>	<input type="checkbox"/>		Polio		
<input type="checkbox"/>	<input type="checkbox"/>		Measles/mumps/rubella		
<input type="checkbox"/>	<input type="checkbox"/>		Whooping cough		
<input type="checkbox"/>	<input type="checkbox"/>		Hepatitis A		
<input type="checkbox"/>	<input type="checkbox"/>		Hepatitis B		
<input type="checkbox"/>	<input type="checkbox"/>		Meningitis		
<input type="checkbox"/>	<input type="checkbox"/>		Philaenia		
<input type="checkbox"/>	<input type="checkbox"/>		Other (List)		
<input type="checkbox"/>	<input type="checkbox"/>		Complete all immunizations (none required)		

Please list any additional information about your medical history:

DO NOT WRITE IN THIS BOX

Parent/guardian signature: _____ Date: _____
 Further approval required: Yes No

Participant signature: _____ Date: _____

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