

TREASURE VALLEY SCOUT RESERVATION  
HEALTH AND MEDICAL RECORD (MEETS BSA CLASS 3 REQUIREMENTS)

This Health and Medical Record is required for participation in resident camp at Treasure Valley. Each participant at Treasure Valley is subject to a medical recheck. Treasure Valley recognizes the right of 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 St., Worcester, MA, 01609 for a copy of the statement required.

**-- DIRECTIONS – IMPORTANT – PLEASE READ – DIRECTIONS – IMPORTANT –**

<p>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 430.154(A)). Adults 40 years of age or over must show evidence of physical exam within the past 12 months (BSA National Standards). DIRECTIONS: 1. Complete Identifying Information, Emergency Information/Health History, and Medications. 2. Physician’s Office verifies immunization History and SIGNS WHERE INDICATED. 3. Health care provider completes physical examination and SIGNS WHERE INDICATED – <u>OR</u> – Attached SIGNED report of physical examination conducted during the preceding 24 months (for person 40 years of age and over, within the preceding 12 months.) 4. Participant , or parent/guardian of participant under 18 years of age, SIGNS WHERE INDICATED. 5. DO NOT mail this form anywhere!!! Bring it to camp, and bring it to medical recheck.</p>	<p><b>THIS FORM MUST BE FILLED OUT COMPLETELY AND CORRECTLY, OR THE INDIVIDUAL WILL NOT BE ADMITTED TO CAMP, PER STATE AND BSA REGULATIONS.</b></p>
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IDENTIFYING INFORMATION-PARENT OR PARTICIPANT PLEASE COMPLETE

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_ Sex \_\_\_ Troop \_\_\_\_\_

Address \_\_\_\_\_ City and State \_\_\_\_\_ Zip \_\_\_\_\_

IN THE EVENT OF EMERGENCY, PLEASE NOTIFY (GIVE FULL NAMES, AREA CODES, AND TELEPHONE NUMBERS)

Mother \_\_\_\_\_ Home Tel \_\_\_\_\_ Work Tel \_\_\_\_\_ Beeper \_\_\_\_\_  
or Guardian

Father \_\_\_\_\_ Home Tel \_\_\_\_\_ Work Tel \_\_\_\_\_ Beeper \_\_\_\_\_  
or Guardian

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

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Home Tel \_\_\_\_\_ Work Tel \_\_\_\_\_

Parents’ vacation address, if any \_\_\_\_\_ Tel \_\_\_\_\_

Insurance Co. or HMO \_\_\_\_\_ Policy No. \_\_\_\_\_  
Tel \_\_\_\_\_

Insurance CO. or HMO address \_\_\_\_\_ City and State \_\_\_\_\_ Zip \_\_\_\_\_

Please attach photocopy of insurance card. If family has no insurance, state “NONE”

Physician’s Name \_\_\_\_\_ City and State \_\_\_\_\_

Tel \_\_\_\_\_

**EMERGENCY INFORMATION/HEALTH HISTORY – PARENT OR PARTICIPANT PLEASE COMPLETE**

EMERGENCY INFORMATION – Has or is subject to (check and give details):

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                       Convulsions                       Heart Trouble                       Contact Lenses  
 Diabetes                       Fainting spells                       Bleeding                       Dentures

Details \_\_\_\_\_

**HEALTH HISTORY**

Is parent/participant aware of any current health problems?  No  Yes Detail \_\_\_\_\_

Is participant under medical care for any reason?  No  Yes Detail \_\_\_\_\_

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	<input type="checkbox"/> No <input type="checkbox"/> Yes	Bridge	<input type="checkbox"/> No <input type="checkbox"/> Yes	Sugar	<input type="checkbox"/> No <input type="checkbox"/> Yes
Serious injury	<input type="checkbox"/> No <input type="checkbox"/> Yes	Chest, lungs	<input type="checkbox"/> No <input type="checkbox"/> Yes	Infection	<input type="checkbox"/> No <input type="checkbox"/> Yes
Deformity	<input type="checkbox"/> No <input type="checkbox"/> Yes	Heart	<input type="checkbox"/> No <input type="checkbox"/> Yes	Bed – wetting	<input type="checkbox"/> No <input type="checkbox"/> Yes
Surgery	<input type="checkbox"/> No <input type="checkbox"/> Yes	Murmur	<input type="checkbox"/> No <input type="checkbox"/> Yes	Menstrual problem	<input type="checkbox"/> No <input type="checkbox"/> Yes
Skin, glands	<input type="checkbox"/> No <input type="checkbox"/> Yes	Rheumatic fever	<input type="checkbox"/> No <input type="checkbox"/> Yes	Hernia (rupture)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Ears, eyes	<input type="checkbox"/> No <input type="checkbox"/> Yes	Stomach, bowels	<input type="checkbox"/> No <input type="checkbox"/> Yes	Back, limbs, joints	<input type="checkbox"/> No <input type="checkbox"/> Yes
Nose, sinus	<input type="checkbox"/> No <input type="checkbox"/> Yes	Appendicitis	<input type="checkbox"/> No <input type="checkbox"/> Yes	Sleepwalking	<input type="checkbox"/> No <input type="checkbox"/> Yes
Teeth, tonsils	<input type="checkbox"/> No <input type="checkbox"/> Yes	Kidneys or urine	<input type="checkbox"/> No <input type="checkbox"/> Yes	Nervous condition	<input type="checkbox"/> No <input type="checkbox"/> Yes
Dentures	<input type="checkbox"/> No <input type="checkbox"/> Yes	Albumin	<input type="checkbox"/> No <input type="checkbox"/> Yes	Tuberculosis	<input type="checkbox"/> No <input type="checkbox"/> Yes

Detail \_\_\_\_\_

**MEDICATIONS – PARENT OR PARTICIPANT PLEASE COMPLETE**

Is the camper or staff member under 18 years of age bringing any medication, prescription or over the counter, to camp?  No  Yes If Yes, please complete the Authorization to Administer Medication to a Camper or Staff Member under 18 years of Age section on Page 4

Is the adult participant 18 years of age and over bringing any medication to camp?  No  Yes If yes, please list:

\_\_\_\_\_  
 \_\_\_\_\_

**IMMUNIZATIONS – PER MASS. DPH – PARENT, PARTICIPANT, AND PHYSICIAN’S OFFICE PLEASE COMPLETE**

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\* \_\_\_\_\_

\*For summer 2000, required for those entering grades K-4 and 7-12 in the fall of 2000.

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.

FOR STAFF AND ADULT LEADERS 18 YEARS OF AGE OR OLDER (Please indicate dates on lines below)

Measles: Born before 1957 \_\_\_\_\_, OR Laboratory evidence of immunity \_\_\_\_\_, OR Dose 1 \_\_\_\_\_ AND  
 Dose 2 \_\_\_\_\_

Mumps: Born before 1957 \_\_\_\_\_, OR Laboratory evidence of immunity \_\_\_\_\_, OR Dose 1 \_\_\_\_\_

Rubella: Laboratory evidence of immunity \_\_\_ OR Dose 1 \_\_\_\_\_

Diphtheria and Tetanus Toxoids\*: Dose 1 \_\_\_\_\_ Dose 2 \_\_\_\_\_ Dose 3 \_\_\_\_\_ Booster \_\_\_\_\_

\* A booster does 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 – LICENSED HEALTH CARE PROVIDER PLEASE COMPLETE**

Height _____	Weight _____	VISION		HEARING	
B.P. _____ / _____	Pulse _____	Normal _____	Glasses _____	Contacts _____	Normal _____
					Abnormal _____

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): \_\_\_\_\_

SIGNED \_\_\_\_\_ Date \_\_\_\_\_  
 Health Care Practitioner Licensed to Perform Physical Examinations

Telephone (\_\_\_\_) \_\_\_\_\_ Address \_\_\_\_\_

**PARENTAL STATEMENT – PARENT OR PARTICIPANT PLEASE READ & SIGN**

I, the undersigned, have read and understood this entire form. The information provided above is accurate and complete. The person described herein has permission for full participation in 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 judgement of medical personnel dictates. These measures may include but are not limited to treatment in camp, transportation to an 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.

*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.*

I also consent to either mine or my camper’s picture, video, likeness, or written comments used in future promotional materials for Treasure Valley Scout Reservation or the Mohegan Council, Inc., Boy Scouts of America without compensation or reprise.

**PARTICIPANT’S SIGNATURE** (IF 18 OR OLDER) \_\_\_\_\_ Date \_\_\_\_\_

**PARENT/GUARDIAN SIGNATURE** \_\_\_\_\_ Date \_\_\_\_\_  
(IF PARTICIPANT IS UNDER 18)

**AUTHORIZATION TO ADMINISTER MEDICATION TO CAMPER OR STAFF MEMBER UNDER 18 YEARS OF AGE**

NAME OF MEDICATION	DOSAGE	WHEN TAKEN*
1. _____		
2. _____		
3. _____		
4. _____		

State any specific directions, precautions, or possible side effects/adverse reactions to any of the above:

\_\_\_\_\_

\*If given PRN (as needed), parent/guardian must define what “as needed” means for his/her child. If dosage is different than shown on container label, then a written doctor’s order must accompany this form. ALL medications must be in their original containers!

I hereby authorize the Treasure Valley medical staff to administer to my child the medications listed above.

**PARENT/GUARDIAN SIGNATURE** \_\_\_\_\_ Date \_\_\_\_\_

**TROOP LEADER AND CAMP SCREENING**

REVIEWED BY TROOP LEADER – SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

SCREENED AT CAMP BY \_\_\_\_\_ DATE \_\_\_\_\_ OK

NOTES \_\_\_\_\_

SCREENED AT CAMP BY \_\_\_\_\_ DATE \_\_\_\_\_ OK

NOTES \_\_\_\_\_