

Class 3 Medical Form (ADULTS)

CLINTON VALLEY COUNCIL #276 -- BOY SCOUTS OF AMERICA

Adults under 40: This form is valid for 3 years.

Adults are required to update, sign and date the health history portion of this form annually during this 3 year period.

If you turn 40 during this 3 year period, you are required to complete a new form on an annual basis.

Adults 40 & above: This form must be completed annually. (A physician's signature is required annually.)

CAMPER INFORMATION

Name: _____ Age: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Council: _____ Unit No.: Pack _____ Troop _____ Post _____

IN CASE OF EMERGENCY, NOTIFY:

Name: _____ Relationship: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Phone: Day _____ Evening: _____ Other: _____

INSURANCE INFORMATION

Family Insurance Company: _____ Contract/Group No.: _____
 Signature of Parent/Guardian: _____

HEALTH HISTORY : Indicate any of following which you have had or currently have

Have you ever had:	YES	NO	Have you ever had:	YES	NO	Have you ever had:	YES	NO	Have you ever had:	YES	NO
Fainting			Asthma			Blurred Vision			Shortness of Breath		
Diphtheria			Diabetes			Headaches			Frequent Urination		
Scarlet Fever			Hear Disease			Fainting			Cough		
Rheumatism			Kidney Disease			Convulsions			Nosebleeds		
Hernia			Tuberculosis			Blackouts			Freq. Sore Throats		
Rheumatic Fever			Jaundice			Painful Joints			Stomach Pains		
Poliomyelitis			Easy Fatiguibility			Backaches			Epilepsy		
Pneumonia			Cancer/Leukaemia			Pounding Heart					

MEDICATIONS: Please list any medication, prescribed by a physician, that you are currently taking.

Prescribed Medications: _____

ALLERGIES: Please list any food, medications, insects, plants that you are allergic to.

Allergy: _____ Explanation: _____
 Allergy: _____ Explanation: _____
 Allergy: _____ Explanation: _____

PHYSICAL EXAMINATION

System	Norm.	Abn.	System	Norm.	Abn.	System	Norm.	Abn.	System	Norm.	Abn.
Urinalysis			Nose			Chest			Hernia		
Vision			Throat			Lungs			Genitalia		
Blood Pressure			Teeth/Cavities			Heart			Neurologic		
Pulse Rate			Orthopaedic			Abdomen			Muscular		
Ears			Thyroid								

IMMUNIZATIONS: Please provide immunization record and date of last inoculation.

DTP/DT/Dt (tetanus): Date _____ MMR: Date _____ Haemophilus Influenza Type B: Date _____
 Other: _____

TO BE COMPLETED BY A LICENSED PHYSICIAN:

I certify that I have examined (name) _____ on (date) _____ and find him/her physically fit to participate in all Scouting activities except as noted below. The aforementioned individual has all required immunizations current as required by the State of Michigan and is free of infectious diseases.

Restrictions and/or Recommendations:

Physician's Signature: _____ Printed Name of Examiner: _____
 Address: _____ Office Phone Number: _____
 Alternative Method of Contact (Answering Service, Beeper): _____

NAME: _____ UNIT # _____ CAMP SITE: _____ WEEK: _____

Answers to the following are required:

1. Registered position in Scouting (If not registered, your relationship to camping unit):

2. Position of responsibility with camping unit while in camp:

3. Additional Information. (Circle Each Answer)

- | | | | |
|----|--|-----|----|
| a. | Do you use illegal drugs? | Yes | No |
| b. | Have you ever been convicted of a criminal offence?
(If yes, explain below) | Yes | No |
| c. | Have you ever been charged with child neglect or abuse? | Yes | No |
| d. | Has your driver's license ever been suspended or revoked? | Yes | No |
| e. | Other than above, is there any fact or circumstance involving you or your background that would call into question your being entrusted with the supervision, guidance, and care of young people?
(If yes, explain below) | Yes | No |

Explanation: _____

The information contained in this form is true and correct to the best of my knowledge.

Signature: _____ Date: _____

REQUIRED REFERENCES

Secure three signatures from the individuals who serve in one of the following capacities with your unit. (Unit Commissioner, Committee Chair, Charter Representative, Head of Chartered Organization, a maximum of one committee member)

As a representative for the chartering organization/troop, I recommend the above-identified individual to serve as a leader of out Scouts in summer camp.

Signature: _____ Position: _____ Date: _____

Signature: _____ Position: _____ Date: _____

Signature: _____ Position: _____ Date: _____