

# Class 2 Medical Form - (YOUTH)

CLINTON VALLEY COUNCIL #276 -- BOY SCOUTS OF AMERICA

## 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			Frequent Sore Throats		
Rheumatic Fever			Jaundice			Painful Joints			Stomach Pains		
Poliomyelitis			Easy Fatigibility			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: \_\_\_\_\_  
 Answering Service Phone Number/Beeper Number/Alternative Method of Contact: \_\_\_\_\_

NAME: \_\_\_\_\_ UNIT #: \_\_\_\_\_ CAMP SITE: \_\_\_\_\_ WEEK: \_\_\_\_\_

**Parent/Guardian Authorization Related to Physical  
Activities and Medical Treatment**

1. So far as I know, the health history contained herein is correct. Therefore, the person herein described has permission to engage in all prescribed activities, except as noted by the physician and me.
  
2. Are there any health or behavioural considerations that adult staff or Troop Leaders should be made aware of? If so, please note: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  
3. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by a designated representative of the Boy Scouts of America to authorize emergency medical or surgical treatment, routine non-surgical medical care, hospitalise, secure proper anaesthesia, or to order injection(s) for my child.
  
4. The person herein described is in good health and has all required immunization current, and I assume the health responsibility for the individual.

*(A youth's Health & Medical Record is required to be completed only once during a three-year period by a physician therefore the parent/guardian may choose to update this Health & Medical Record and sign without a physician's signature for the second and third year. Each signature is good for one year but can not exceed the three-year anniversary of the original examination date.)*

1<sup>st</sup> Year: Date \_\_\_\_\_ Signature of Parent or Guardian: \_\_\_\_\_

Any changes to First Year? \_\_\_\_\_

2<sup>nd</sup> Year: Date \_\_\_\_\_ Signature of Parent or Guardian: \_\_\_\_\_

3<sup>rd</sup> Year: Date \_\_\_\_\_ Signature of Parent or Guardian: \_\_\_\_\_