



Blue Ridge Mountains
Scout Reservation

ADMINISTRATION

BLUE RIDGE MOUNTAINS COUNCIL

CAMP MEDICAL FORM

Name

Instructions: This two-sided form is required for all youth and adults staying 72 hours or more at one of the Blue Ridge Mountains Council Camps. This medical record is a complete health history that requires a physician's signature indicating that the youth or adult is fit to attend the event. Youth and adults without a completed medical form will not be allowed to participate and will be sent home. *Please make copies of this form, it will not be returned to you at the end of the event.*

I. Personal information and Emergency Contact Information

Name: _____ Date of Birth: _____ Age: _____ Sex: _____

Address: _____ City: _____ State: _____ Zip: _____

Unit Number (Troop, Post, Crew): _____ Council: _____

Name of Parent or Guardian: _____ Work Phone: _____ Home Phone: _____

If person named above is not available in the event of an emergency, please contact:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Persons NOT authorized to take youth from the event:

II. Insurance

Personal health/accident insurance provider: _____ Policy No. _____

**Please attach a copy of the front and back of your insurance card to this form.*

III. Health History/Information

Primary Physician: _____

Physician's Phone: _____

Dentist/Orthodontist: _____

Dentist/Ortho. Phone: _____

Is there disease of (or past or present history of):

Details:

Serious Illness _____

Serious Injury _____

Deformity _____

Surgery _____

Skin, glands _____

Ears, eyes _____

Nose, sinus _____

Teeth, tonsils _____

Chest, lungs _____

Heart _____

Stomach, bowels _____

Appendicitis _____

Kidneys, urine _____

Menstrual problems _____

Hernia (rupture) _____

Back, limbs, joints _____

Sleepwalking _____

Nervous condition _____

Other (explain) _____

Emergency Medical Information

Has or is subject to:

(Please Check)

Details:

ADD/ADHD _____

Asthma _____

Diabetes _____

Convulsions _____

Fainting Spells _____

Heart Trouble _____

Bleeding Disorders _____

Contact Lenses _____

Dentures _____

Allergies (please list) _____

Any conditions requiring special care, diet,
or medications? _____

Unit

Council

IV. Health Examination

- Youth Base Camp (Powhatan, Ottari, Brownsea)–Signed physical within 36 months
- Youth High Adventure (NR, FC, MM, HK, Voy, Claytor, SCUBA, Wake Boarding)–Signed physical within 12 months
- Adults over 40 years old–Mandatory physical within 12 months (if under 40 refer to youth)

Licensed Health Care Practitioner:

The applicant may be participating in a strenuous activity that will include one or more of the following conditions: athletic competitions, adventure challenge or wilderness expedition (afloat or afoot) that may include extreme weather conditions, cold water, exposure, fatigue, and/or remote conditions where readily available medical care cannot be assured.

- Please insist applicant complete page 1 prior to exam
- Review immunizations and ensure they are current
- After completing the physical exam, please summarize any restrictions and/or recommendations.

Height: _____ Weight: _____ BP: _____ Pulse: _____

Check box if normal; circle if abnormal and give details:

- | | |
|--|---|
| <input type="checkbox"/> Growth, Development | <input type="checkbox"/> Skin, Glands, Hair |
| <input type="checkbox"/> Head, Neck, Thyroid | <input type="checkbox"/> Eyes, Ears, Nose |
| <input type="checkbox"/> Teeth, Tonsils | <input type="checkbox"/> Respiratory |
| <input type="checkbox"/> Cardiovascular | <input type="checkbox"/> Abdomen, Hernia |
| <input type="checkbox"/> Genitourinary | <input type="checkbox"/> Skeletomuscular |
| <input type="checkbox"/> Neuropsychiatric | <input type="checkbox"/> Other (specify) |

Details: _____

Immunization Records

If disease, put "D" & Year or list last year given

Tetanus _____	Mumps _____
Diphtheria _____	Rubella _____
Pertussis _____	Polio _____
Measles _____	Chicken Pox _____

I have examined the individual and found him/her to be in satisfactory condition with the following exceptions:

In my opinion, this individual IS IS NOT able to participate in all activities.

Recommendations or Restrictions: _____

Treatments to Continue at event: _____

Medications (include dosage) to continue at event: _____

Licensed Physician's Signature: _____ Date: _____

V. Parent/Minor Signatures

- This section must be signed and updated annually, Base Camp participants may attach last year's signed physical.

To the best of my knowledge, the information on this form is correct. I hereby give permission to the person herein described to engage in all prescribed camp activities, on or off property, except as noted.

In Case of Emergency, I understand every effort will be made to contact me (if participant is an adult, my spouse or next of kin). In the event that I cannot be reached, I hereby give my permission to the licensed health-care practitioner selected by the camp administration to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child (or for me, if participant is an adult. Permission is given to transport me or my child for medical assistance. This form may be photocopied for use at camp. I understand that I am responsible for payment of all medical treatments received.

If I or my child need medical treatment, I hereby authorize any doctor or hospital treating the Scout while he is at camp to discuss and release information regarding such treatment or follow-up care to any of the following representatives of the BOY SCOUTS OF AMERICA, Blue Ridge Mountains Council: Greg Harmon, Program Director and Tommy Pendleton, Reservation Director. I understand that this authorization will remain in effect while I or the Scout is at summer camp and will expire no later than August 15, 2008.

Signature Parent/Guardian (or participant if over 18): _____ Date: _____

Signature of Minor: _____ Date: _____