



NASHUA VALLEY COUNCIL

Boy Scouts of America, Inc.

1980 Lunenburg Road • Lancaster, Massachusetts 01523 • Phone (978) 534-3532 • Fax (978) 534-4618

IMPORTANT INFORMATION REGARDING 2011 MEDICAL FORMS PLEASE READ CAREFULLY

**2011 Medical Forms can be downloaded from:
www.campsplitrock.org and www.campwanocksett.org**

Effective January 1, 2010 the Boy Scouts of America began using a new "Annual Health and Medical Record" form. This new form replaces the old Class I, Class II, Class III forms. Nashua Valley Council will be using the new form for all summer camp programs. Items to note on this form include:

- **You must have a physical within 12 months of attending camp.** This is a change from the previous forms' requirement of 24 months for those under age 40. All adults and youth should schedule a physical if their last exam was more than 12 months prior to the date you will attend camp.
- **Parents/Guardians and Physicians must sign the medication section on page 2.** The physician's signature confirms the prescription; the parent's signature authorizes the camp health officer to administer the medication.
- **A licensed health care professional must complete and sign the physical examination report on page 3.**
- The participant and parent or guardian (if participant is under 18) must sign informed consent and talent release on Page 4.
- **Please list those individuals who are authorized to sign your Scout out of camp. You may also specify individuals who are not authorized to sign your Scout out under any circumstances. Anyone signing a Scout out of camp will be required to show a photo id.**
- **Attach a copy of your immunization record.** The Commonwealth of Massachusetts requirements are included for reference. An accurate, current immunization report from your health care provider will enable us to better treat your Scout in the event that emergency care is needed.
- The height and weight guidelines in this form apply to high adventure programs only. They do not apply to summer camp, although Nashua Valley Council encourages youth and adult members to use these guidelines in seeking to improve their own personal fitness.
- **ALWAYS Submit a copy of your med form. Keep the original for your own records.** State law requires that Nashua Valley Council retain medical forms for two years. They will not be returned at the end of your week at camp, and will not be accessible for future events. We do not have the ability to make large quantities of photocopies at camp.

Annual Health and Medical Record

(Valid for 12 calendar months)

Medical Information

The Boy Scouts of America recommends that all youth and adult members have annual medical evaluations by a certified and licensed health-care provider. In an effort to provide better care to those who may become ill or injured and to provide youth members and adult leaders a better understanding of their own physical capabilities, the Boy Scouts of America has established minimum standards for providing medical information prior to participating in various activities. Those standards are offered below in one three-part medical form. Note that unit leaders must always protect the privacy of unit participants by protecting their medical information.

Parts A and C are to be completed annually **by all BSA unit members**. Both parts are required for all events that do not exceed 72 consecutive hours, where the level of activity is similar to that normally expended at home or at school, such as day camp, day hikes, swimming parties, or an overnight camp, and where medical care is readily available. Medical information required includes a current health history and list of medications. Part C also includes the parental informed consent and hold harmless/release agreement (with an area for notarization if required by your state) as well as a talent release statement. Adult unit leaders should review participants' health histories and become knowledgeable about the medical needs of the youth members in their unit. This form is to be filled out by participants and parents or guardians and kept on file for easy reference.

Part B is required with parts A and C for any event that exceeds 72 consecutive hours, or when the nature of the activity is strenuous and demanding, such as a high-adventure trek. Service projects or work weekends may also fit this description. It is to be completed and signed by a certified and licensed health-care provider—physician (MD, DO), nurse practitioner, or physician's assistant as appropriate for your state. The level of activity ranges from what is normally expended at home or at school to strenuous activity such as hiking and backpacking. Other examples include tour camping, jamborees, and Wood Badge training courses. It is important to note that the height/weight limits must be strictly adhered to if the event will take the unit beyond a radius wherein emergency evacuation is more than 30 minutes by ground transportation, such as backpacking trips, high-adventure activities, and conservation projects in remote areas.

Risk Factors

Based on the vast experience of the medical community, the BSA has identified that the following risk factors may define your participation in various outdoor adventures.

- Excessive body weight
- Heart disease
- Hypertension (high blood pressure)
- Diabetes
- Seizures
- Lack of appropriate immunizations
- Asthma
- Sleep disorders
- Allergies/anaphylaxis
- Muscular/skeletal injuries
- Psychiatric/psychological and emotional difficulties

For more information on medical risk factors, visit Scouting Safely on www.scouting.org.

Prescriptions

The taking of prescription medication is the responsibility of the individual taking the medication and/or that individual's parent or guardian. A leader, after obtaining all the necessary information, can agree to accept the responsibility of making sure a youth takes the necessary medication at the appropriate time, but BSA does not mandate or necessarily encourage the leader to do so. Also, if state laws are more limiting, they must be followed.

For frequently asked questions about this Annual Health and Medical Record, see Scouting Safely online at <http://www.scouting.org/scoutsource/HealthandSafety.aspx>. Information about the Health Insurance Portability and Accountability Act (HIPAA) may be found at <http://www.hipaa.org>.



BOY SCOUTS OF AMERICA.

Annual BSA Health and Medical Record

Part A

GENERAL INFORMATION

Name _____ Date of birth _____ Age _____ Male Female
 Address _____ Grade completed (youth only) _____
 City _____ State _____ Zip _____ Phone No. _____
 Unit leader _____ Council name/No. _____ Unit No. _____
 Social Security No. (optional; may be required by medical facilities for treatment) _____ Religious preference _____
 Health/accident insurance company _____ Policy No. _____

ATTACH A PHOTOCOPY OF BOTH SIDES OF INSURANCE CARD (SEE PART C). IF FAMILY HAS NO MEDICAL INSURANCE, STATE "NONE."

In case of emergency, notify:

Name _____ Relationship _____
 Address _____
 Home phone _____ Business phone _____ Cell phone _____
 Alternate contact _____ Alternate's phone _____

MEDICAL HISTORY

Are you now, or have you ever been treated for any of the following:

| Yes | No | Condition | Explain |
|-----|----|--|---------|
| | | Asthma | |
| | | Diabetes | |
| | | Hypertension (high blood pressure) | |
| | | Heart disease (i.e., CHF, CAD, MI) | |
| | | Stroke/TIA | |
| | | COPD | |
| | | Ear/sinus problems | |
| | | Muscular/skeletal condition | |
| | | Menstrual problems (women only) | |
| | | Psychiatric/psychological and emotional difficulties | |
| | | Learning disorders (i.e., ADHD, ADD) | |
| | | Bleeding disorders | |
| | | Fainting spells | |
| | | Thyroid disease | |
| | | Kidney disease | |
| | | Sickle cell disease | |
| | | Seizures | |
| | | Sleep disorders (i.e., sleep apnea) | |
| | | GI problems (i.e., abdominal, digestive) | |
| | | Surgery | |
| | | Serious injury | |
| | | Other | |

Allergies or Reaction to:

Medication _____
 Food, Plants, or Insect Bites _____

Immunizations:

The following are recommended by the BSA. Tetanus immunization must have been received within the last 10 years. If had disease, put "D" and the year. If immunized, check the box and the year received.

| Yes | No | Date |
|--------------------------|--------------------------|-------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Tetanus _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Pertussis _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Diphtheria _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Measles _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Mumps _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Rubella _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Polio _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Chicken pox _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis A _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis B _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Influenza _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Other (i.e., HIB) _____ |

Exemption to immunizations claimed.

MEDICATIONS

List all medications currently used. (If additional space is needed, please photocopy this part of the health form.) Inhalers and EpiPen information must be included, even if they are for occasional or emergency use only.

(For more information about immunizations, as well as the immunization exemption form, see Scouting Safely on Scouting.org.)

| | | |
|---|---|---|
| Medication _____ Strength _____ Frequency _____ Approximate date started _____ Reason for medication _____ _____ Distribution approved by: _____ Parent signature _____ MD/DO, NP, or PA Signature Temporary <input type="checkbox"/> Permanent <input type="checkbox"/> | Medication _____ Strength _____ Frequency _____ Approximate date started _____ Reason for medication _____ _____ Distribution approved by: _____ Parent signature _____ MD/DO, NP, or PA Signature Temporary <input type="checkbox"/> Permanent <input type="checkbox"/> | Medication _____ Strength _____ Frequency _____ Approximate date started _____ Reason for medication _____ _____ Distribution approved by: _____ Parent signature _____ MD/DO, NP, or PA Signature Temporary <input type="checkbox"/> Permanent <input type="checkbox"/> |
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NOTE: Be sure to bring medications in the appropriate containers, and make sure that they are **NOT expired, including inhalers and EpiPens. You **SHOULD NOT STOP** taking any maintenance medication.**

Emergency contact No.:

Allergies:

DOB:

Last name:

Part B

PHYSICAL EXAMINATION

Height _____ Weight _____ % body fat _____ Meets height/weight limits Yes No
 Blood pressure _____ Pulse _____

Individuals desiring to participate in any high-adventure activity or event in which emergency evacuation would take longer than 30 minutes by ground transportation will not be permitted to do so if they exceed the height/weight limits as documented in the table at the bottom of this page or if during a physical exam their health care provider determines that body fat percentage is outside the range of 10 to 31 percent for a woman or 2 to 25 percent for a man. Enforcing this limit is strongly encouraged for all other events, but it is not mandatory. (For healthy height/weight guidelines, visit www.cdc.gov.)

| | Normal | Abnormal | Explain Any Abnormalities | Range of Mobility | Normal | Abnormal | Explain Any Abnormalities |
|--|--------|----------|---------------------------|--|------------|-----------|---------------------------|
| Eyes | | | | Knees (both) | | | |
| Ears | | | | Ankles (both) | | | |
| Nose | | | | Spine | | | |
| Throat | | | | | | | |
| Lungs | | | | Other | Yes | No | |
| Heart | | | | Contacts | | | |
| Abdomen | | | | Dentures | | | |
| Genitalia | | | | Braces | | | |
| Skin | | | | Inguinal hernia | | | Explain |
| Emotional adjustment | | | | Medical equipment (i.e., CPAP, oxygen) | | | |
| Tuberculosis (TB) skin test (if required by your state for BSA camp staff) <input type="checkbox"/> Negative <input type="checkbox"/> Positive | | | | | | | |

Allergies (to what agent, type of reaction, treatment): _____

I certify that I have, today, reviewed the health history, examined this person, and approve this individual for participation in:

- Hiking and camping Competitive activities Backpacking Swimming/water activities Climbing/rappelling
- Sports Horseback riding Scuba diving Mountain biking Challenge ("ropes") course
- Cold-weather activity (<10°F) Wilderness/backcountry treks

Specify restrictions (if none, so state) _____

Certified and licensed health-care providers recognized by the BSA to perform this exam include physicians (MD, DO), nurse practitioners, and physician's assistants.

- To Health Care Provider:** Restricted approval includes:
- Uncontrolled heart disease, asthma, or hypertension.
 - Uncontrolled psychiatric disorders.
 - Poorly controlled diabetes.
 - Orthopedic injuries not cleared by a physician.
 - Newly diagnosed seizure events (within 6 months).
 - For scuba, use of medications to control diabetes, asthma, or seizures.

Provider printed name _____

Signature _____

Address _____

City, state, zip _____

Office phone _____

Date _____

| Height (inches) | Recommended Weight (lbs) | Allowable Exception | Maximum Acceptance |
|-----------------|--------------------------|---------------------|--------------------|
| 60 | 97-138 | 139-166 | 166 |
| 61 | 101-143 | 144-172 | 172 |
| 62 | 104-148 | 149-178 | 178 |
| 63 | 107-152 | 153-183 | 183 |
| 64 | 111-157 | 158-189 | 189 |
| 65 | 114-162 | 163-195 | 195 |
| 66 | 118-167 | 168-201 | 201 |
| 67 | 121-172 | 173-207 | 207 |
| 68 | 125-178 | 179-214 | 214 |
| 69 | 129-185 | 186-220 | 220 |

| Height (inches) | Recommended Weight (lbs) | Allowable Exception | Maximum Acceptance |
|-----------------|--------------------------|---------------------|--------------------|
| 70 | 132-188 | 189-226 | 226 |
| 71 | 136-194 | 195-233 | 233 |
| 72 | 140-199 | 200-239 | 239 |
| 73 | 144-205 | 206-246 | 246 |
| 74 | 148-210 | 211-252 | 252 |
| 75 | 152-216 | 217-260 | 260 |
| 76 | 156-222 | 223-267 | 267 |
| 77 | 160-228 | 229-274 | 274 |
| 78 | 164-234 | 235-281 | 281 |
| 79 & over | 170-240 | 241-295 | 295 |

This table is based on the revised Dietary Guidelines for Americans from the U.S. Dept. of Agriculture and the Dept. of Health & Human Services.

Part B **Last name:** _____ **DOB:** _____

Part C

Informed Consent and Hold Harmless/Release Agreement

I understand that participation in Scouting activities involves a certain degree of risk. I have carefully considered the risk involved and have given consent for myself and/or my child to participate in these activities. I understand that participation in these activities is entirely voluntary and requires participants to abide by applicable rules and standards of conduct. I release the Boy Scouts of America, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with the activity from any and all claims or liability arising out of this participation.

I approve the sharing of the information on this form with BSA volunteers and professionals who need to know of medical situations that might require special consideration for the safe conducting of Scouting activities.

In case of an emergency involving me or my child, I understand that every effort will be made to contact the individual listed as the emergency contact person. In the event that this person cannot be reached, permission is hereby given to the medical provider selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for me or my child. Medical providers are authorized to disclose to the adult in charge Protected Health Information/Confidential Health Information (PHI/CHI) under the Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. §§160.103, 164.501, etc. seq., as amended from time to time, including examination findings, test results, and treatment provided for purposes of medical evaluation of the participant, follow-up and communication with the participant's parents or guardian, and/or determination of the participant's ability to continue in the program activities.

- Without restrictions.
- With special considerations or restrictions (list) _____

I hereby assign and grant to the local council and the Boy Scouts of America the right and permission to use and publish the photographs/film/videotapes/electronic representations and/or sound recordings made of me or my child at all Scouting activities, and I hereby release the Boy Scouts of America, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with the activity from any and all liability from such use and publication.

I hereby authorize the reproduction, sale, copyright, exhibit, broadcast, electronic storage, and/or distribution of said photographs/film/videotapes/electronic representations and/or sound recordings without limitation at the discretion of the Boy Scouts of America, and I specifically waive any right to any compensation I may have for any of the foregoing.

- Yes No

Adults authorized to take youth to and from the event: (You must designate at least one adult. Please include a telephone number.)

Adults NOT authorized to take youth to and from the event:

- 1. _____
- 2. _____
- 3. _____

- 1. _____
- 2. _____
- 3. _____

I understand that, if any information I/we have provided is found to be inaccurate, it may limit and/or eliminate the opportunity for participation in any event or activity.


Participant's name _____

Participant's signature _____

Parent/guardian's signature _____
(if under the age of 18)

Date _____

Attach copy of insurance card (front and back) here. If required by your state, use the space provided here for notarization.



BOY SCOUTS OF AMERICA
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<http://www.scouting.org>

SKU 34605



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Part C Last name: _____ DOB: _____



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Town _____
Unit _____
First _____
Last _____

Scout's Name _____

Troop/Pack _____ Town _____

Over-the-counter Medication

I give the camp health officer, or BSA registered unit leader (for activities other than summer camp), or the designated health officer (for other activities) permission to administer over-the-counter medications, including but not be limited to Tylenol, Advil, or Benadryl as deemed necessary by the camp health officer, BSA registered unit leader (for activities other than summer camp), or the designated health officer (for other activities). Medications indicated under the allergies section of this form will not be administered.

I DO NOT give permission for over-the-counter medications to be administered.

Parent/Guardian Name _____ Date _____

Parent/Guardian Signature _____



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IMPORTANT REQUIRED FOR ALL SUMMER CAMP ATTENDEES

PLEASE ATTACH A COPY OF YOUR CURRENT IMMUNIZATION RECORD

The Commonwealth of Massachusetts Immunization Requirements 105 CMR 430.152-153

Written documentation of immunization shall be required for all campers and staff as follows:

For Campers and Staff under 18 Years Old:

1. **Measles, Mumps and Rubella (MMR) Vaccine:** A minimum of one dose of MMR vaccine(s) must be administered at or after 12 months of age. A second dose of live measles- containing vaccine given at least four weeks after the first, is required for all campers and staff, who will be entering grades K-12 or college in the school year immediately following the camp session (or in case of an ungraded classroom or the camper/staff does not attend school/college, campers or staff five years of age or older). Laboratory evidence of immunity is acceptable.
2. **Polio Vaccine:** A minimum of three doses of either inactivated polio vaccine (IPV) or oral polio vaccine (OPV) are required. If a mixed (IVP/OPV) schedule was used, four doses are required;
3. **Diphtheria and Tetanus Toxoids and Pertussis Vaccine:** A minimum of four doses of DTaP/DTP/DT or at least three doses of Td is required. Where a camper or staff person is seven or more years of age and requires additional immunizations to satisfy 105 CMR 430.152(A)(3), Td is to be substituted for DTaP, DTP or DT vaccine. Effective January 1, 2004, a booster dose of Td is required for all campers and staff who will be entering grades seven through ten (or in the case of an ungraded classroom or the camper or staff does not attend school, campers or staff 12 through 15 years of age) if it has been more than five years since the last dose of DTaP/DTP/DT. For all campers and staff who will be entering grades 11 and 12 (or in the case of an ungraded classroom or the camper or staff does not attend school, campers or staff 16 through 17 years of age) a booster of Td is required if it has been more than ten years since the last dose of DTaP/DTP/DT/Td.
4. **Hepatitis B:** For all children born on or after January 1, 1992, three doses of Hepatitis B vaccine are required. Laboratory evidence of immunity is acceptable.

For Camper and Staff 18 Years of Age or Older:

1. **Measles Vaccine:** Unless born before 1957, two doses of live measles-containing vaccine administered at/or after 12 months of age (at least four weeks apart) are required. Laboratory evidence of immunity is acceptable.
2. **Mumps Vaccine:** Unless born before 1957, at least one dose of mumps vaccine administered at/or after 12 months of age is required. Laboratory evidence of immunity is acceptable.
3. **Rubella Vaccine:** Unless born before 1957, at least one dose of rubella vaccine administered at/or after 12 months of age is required. Laboratory evidence of immunity is acceptable.
4. **Diphtheria and Tetanus Toxoids:** At least three doses of DTaP/DTP/DT/Td are required. A booster dose of tetanus/diphtheria, adult type toxoid (Td) is required if more than ten years have elapsed since the last dose of DTaP/DTP/DT/Td vaccine.

Physical Examinations or Immunizations Excepted (105 CMR 430.153):

1. **Religious Exceptions.** If a camper or staff member has religious objections to physical examinations or immunizations, the camper or staff member shall submit a written statement, signed by a parent or legal guardian of the camper, to the effect that the individual is in good health and stating the reason for such objections.
2. **Immunization Contraindicated.** Any immunization specified in 105 CMR 430.152 shall not be required if the health history required by 105 CMR 430.151 includes a certification by a physician that he or she has examined the individual and that in the physician's opinion the physical condition of the individual is such that his or her health would be endangered by such immunization.