

**PERSONAL HEALTH AND MEDICAL RECORD FORM—Class 3**

**I. IDENTIFICATION** Age \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth\*  
 Name \_\_\_\_\_  
Last name First name Initial Mo. Day Year

Address \_\_\_\_\_  
 City & State \_\_\_\_\_ Zip \_\_\_\_\_  
 Health/Accident Insurance \_\_\_\_\_ Policy no. \_\_\_\_\_

**IN AN EMERGENCY NOTIFY:**  
 Name \_\_\_\_\_ Relationship \_\_\_\_\_  
 Address \_\_\_\_\_ Home phone \_\_\_\_\_  
 City & State \_\_\_\_\_ Business phone \_\_\_\_\_  
 Personal phone \_\_\_\_\_  
 Physician \_\_\_\_\_ Phone \_\_\_\_\_

**III. PARENTAL STATEMENT**  
 Has it ever been necessary to restrict applicant's activities for medical reasons?  No  Yes Does applicant take medicine regularly or have special care?  No  Yes If yes, explain.  
 \_\_\_\_\_  
 To the best of my knowledge, the information in sections I, II, III, IV, and VI is accurate and complete. I request a licensed health-care practitioner to examine applicant, to give needed immunization, and to furnish requested information to other agencies as needed. I give my permission for full participation in BSA programs, subject to limitations noted herein. In the event of illness or accident in the course of such activity, I request that measures be instituted without delay as judgment of medical personnel dictates.  
 Parent or guardian \_\_\_\_\_  
(Must sign if applicant is 18 or younger)  
 Applicant's signature \_\_\_\_\_  
 Date signed \_\_\_\_\_  
 Updated \_\_\_\_\_ Signed \_\_\_\_\_ Parent or guardian  
 Updated \_\_\_\_\_ Signed \_\_\_\_\_ Parent or guardian

**IV. IMMUNIZATIONS**  
 If disease, put "D" and year. Last year given  
 Tetanus \_\_\_\_\_  
 Diphtheria \_\_\_\_\_  
 Pertussis \_\_\_\_\_  
 Measles \_\_\_\_\_  
 Mumps \_\_\_\_\_  
 Rubella \_\_\_\_\_  
 Polio \_\_\_\_\_  
 Chicken Pox \_\_\_\_\_  
 Religious preference \_\_\_\_\_

**BOY SCOUTS OF AMERICA**  
 All Class 3 activities require a health examination within the past 12 months by a licensed health-care practitioner.\* This includes youth and adult members participating in high-adventure activities, athletic competition, and world jamborees. Annually, this form is to be used by adults 40 years of age or older for all activities requiring a physical examination and applies to all Wood Badge participants/staff regardless of age.

**II. EMERGENCY MEDICAL INFORMATION**  
 Has or is subject to (check and give details):  
 Allergy to a medicine, food†, plant, animal, or insect toxin  
 Any condition that may require special care, medication, or diet  
 ADHD (Attention Deficit Hyperactive Disorder)  
 Asthma  Convulsions  Heart trouble  Contact lenses  
 Diabetes†  Fainting spells  Bleeding disorders  Dentures  
 EXPLAIN \_\_\_\_\_

**V. LICENSED HEALTH-CARE PRACTITIONER'S EVALUATION AND ADVICE**  
 Approved for participation in:  
 Hiking and camping  Water activities  
 Competitive sports  All activities  
 Specify exceptions \_\_\_\_\_  
 Recommendations (explain any restrictions OR limitations): \_\_\_\_\_  
 Date \_\_\_\_\_  
 Signed \_\_\_\_\_  
\*Licensed health-care practitioner  
 \*Examinations conducted by licensed health-care practitioners other than physicians will be recognized for BSA purposes in those states where such practitioners may perform physical examinations within their legally prescribed scope of practice.

**PLEASE TYPE OR PRINT.**  
 NAME \_\_\_\_\_  
 UNIT \_\_\_\_\_  
**NOTE:** Keep original form for your personal record. Make reproductions for agency use. Be sure information and signatures are legible on reproduced copies. This upper section may be reproduced and carried with you for emergency identification and care.

**VI. MEDICAL HISTORY**  
 Parent (or applicant if 18 or older): Fill in sections I, II, III, IV, and VI before seeing a licensed health-care practitioner. Check immunizations to be given at this time. Be sure to include any emergency information and restrictions or special care that should be observed. Especially be sure to record any injuries, illnesses, surgery, or significant changes in condition of health of applicant since last complete examination.  
 • Date of most recent complete physical examination (month and year) \_\_\_\_\_ 20\_\_\_\_  
 • Are you aware of any current health problems?  No  Yes  
 • Now under medical care or taking medicines?  No  Yes  
 • Has there been any surgery, injury, illness, allergy, or change in health status since last complete physical examination?  No  Yes  
 Give dates and full details below for any "yes" answers.  
**IS THERE DISEASE OF (OR PAST OR PRESENT HISTORY OF):**

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

Please list ALL medications taken in the 30 days prior to arrival at the Scouting activity where this form is to be used:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**VII. HEALTH EXAMINATION**  
 Licensed Health-Care Practitioner:  
 The applicant will be participating in a strenuous activity that will include one or more of the following conditions: athletic competition, adventure challenge or wilderness expedition (afloat or aloft) that may include high altitude, extreme weather conditions, cold water, exposure, fatigue, and/or remote conditions where readily available medical care cannot be assured.  
 • Please insist applicant furnish complete medical history (VI) before exam.  
 • Review immunizations; for youth (18 or younger) tetanus and diphtheria toxoids, measles, mumps, and rubella vaccines, and trivalent oral polio vaccine are required; youths and adults must have had tetanus booster within 10 years. A measles booster is recommended at age 12.  
 • After completing section VII, summarize any restrictions and/or recommendations in sections II and V, above, and sign.  
 VISION: \_\_\_\_\_ HEARING: \_\_\_\_\_  
 Date \_\_\_\_\_ Normal \_\_\_\_\_ Normal \_\_\_\_\_  
 Ht. \_\_\_\_\_ Wt. \_\_\_\_\_ Glasses \_\_\_\_\_ Abnormal \_\_\_\_\_  
 B.P. \_\_\_\_\_ / \_\_\_\_\_ Pulse \_\_\_\_\_ Contacts \_\_\_\_\_  
 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**  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
**FOR THOSE ATTENDING PHILMONT OR NATIONAL HIGH-ADVENTURE BASES:**  
 \* The minimum age for all participants is 13 by January 1 of the year of participation, or have completed the seventh grade. No exceptions.  
 † Trail food is by necessity a high-carbohydrate, high-calorie diet. It is high in wheat, milk products, sugar, corn syrup, and artificial coloring/flavoring. Dinner meals contain meat. If these food products cause a problem in your diet, you need to bring appropriate substitutions with you and so advise base personnel.  
 Note: Licensed health-care practitioners representing high-adventure bases reserve the right to deny access to the trails or other program activity on the basis of a medical evaluation performed at the base after arrival.

# CERTIFICATE OF IMMUNIZATION

105 CMR 430.152

Written documentation of immunization or alternative proof of immunity shall be required for all campers, adults, and staff as follows:

FIRST NAME \_\_\_\_\_ LAST NAME \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_

CITY/STATE/ZIP \_\_\_\_\_ DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_

PARENT/GUARDIAN \_\_\_\_\_ PHONE \_\_\_\_\_

CAMP AND SESSION(S) ATTENDING \_\_\_\_\_

### For Campers and Staff under 18 Years Old

- 1) **Measles, Mumps and Rubella (MMR) Vaccine:** At least one dose of MMR vaccine(s) must be administered at or after 12 months of age or there must be laboratory evidence of immunity. A second dose of live, measles containing vaccine is required for all campers and staff.  
Both Doses of measles vaccine must be given at least one month apart, and must be given at or after 12 months of age, or laboratory evidence of immunity.
- 2) **Polio Vaccine:** At least three doses of either trivalent oral polio vaccine (OPV) or enhanced potency inactivated polio vaccine (e-IPV) are required. If a mixed schedule of polio vaccine is given (IPV and OPV) a total of four doses is required
- 3) **Diphtheria and Tetanus Toxoids and Pertussis Vaccine:** At least four doses of DtaP/DTP/DT/tD are required (the Pertussis component is not given to anyone seven years of age or older). A booster dose of tetanus/diphtheria, adult type toxoid (Td) is required if more than ten years have elapsed since the last dose.
- 4) **Hepatitis B:** For all children born on or after January 1, 1992, three doses of Hepatitis B vaccine are required.

### For Staff and Adults 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 one month apart) are required, or there must be laboratory evidence of immunity to measles.
- 2) **Mumps Vaccine:** Unless born before 1957, at least one dose of mumps vaccine administered at or after 12 months of age is required, or there must be laboratory proof of immunity to mumps.
- 3) **Rubella Vaccine:** at least one dose of rubella vaccine administered at or after 12 months of age is required, or there must be laboratory proof of immunity to rubella.
- 4) **Diphtheria and Tetanus Toxoids:** At least three doses of DT/dT are required. A booster dose of tetanus/diphtheria, adult type toxoid (dT) is required if more than ten years have elapsed since the last dose.

### 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 for those under 18 years of age, to the effect that the individual is in good health and stating the reason for such objections.
- 2) **Immunizations 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.

### IMMUNIZATION DATES – LIST MONTH AND YEAR

DTP _____	MMR _____
dT _____	MEASLES _____
POLIO _____	MUMPS _____
HIB _____	RUBELLA _____

**FORM MUST BE SIGNED BY AND DATED BY PHYSICIAN OR DESIGNEE (NOT PARENT OR GUARDIAN!)**

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_