



ADULT HEALTH HISTORY & MEDICAL EVALUATION

40+

THIS FORM IS NOT TO BE USED BY YOUTH, OR ADULTS UNDER 40 YEARS OF AGE.

1. If you have had a medical evaluation (physical exam) within the last 12 months, a copy of the results of that examination must be attached to the health history portion of this form for all participants in a summer camping experience.
2. If a copy is not available, a physical exam using the medical evaluation section on the back of this form must be performed **this year prior to camp** by a licensed medical 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.

HEALTH HISTORY To be *filled out and signed annually* by participant.

IDENTIFICATION Please print in ink.

Name _____ Date of birth _____ Age _____ Sex _____

Home address _____ City _____ State _____ Zip _____

Business address _____ City _____ State _____ Zip _____

In the event of an emergency, notify

Name _____ Relationship _____ Telephone _____

Name _____ Relationship _____ Telephone _____

Name of personal physician _____ Telephone _____

Personal health/accident insurance carrier _____ Policy No. _____

Check all items that apply, **past or present**, to your health history. Explain any "Yes" answers.

ALLERGIES: Food, medicines, insects, plants Yes No Explain: _____

GENERAL INFORMATION:		Yes	No	Yes	No	Explain: _____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer/leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Convulsions/seizures	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	_____

List any medications to be taken at camp: _____

List any physical or behavioral conditions that may affect or limit full participation in swimming, backpacking, hiking long distances, or playing strenuous physical games: _____

List equipment needed such as wheelchair, braces, glasses, contact lenses, etc. _____

Immunizations: (give date of last inoculation)

Tetanus toxoid _____	Measles _____	Polio _____
Diphtheria _____	Mumps _____	_____
Pertussis _____	Rubella _____	_____

I am of sufficient health for full participation in BSA program, subject to limitations noted herein.

In case of emergency where I cannot speak for myself, I understand every effort will be made to contact the persons named above. In the event they cannot be reached, I hereby give my permission to the physician selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for myself. I give permission for images of myself to be used in print and web publications that promote council camping facilities.

Date _____ **X** _____

Signature of participant _____

MEDICAL EVALUATION

Read all requirements outlined on the top of page 1

NAME

Name _____ Age _____

NOTE TO LICENSED MEDICAL PRACTITIONERS*: The person being evaluated will be attending 1 or more weeks of camp that may include sleeping on the ground and participating in strenuous activities such as hiking, boating, and vigorous group games. Please review the HEALTH HISTORY with the participant for any interim changes. Explain any "abnormal" evaluations.

PHYSICAL EXAMINATION (To be filled out by a licensed medical practitioner)

Height _____ Weight _____ BP _____ / _____ Pulse _____

Lab: Urinalysis (dipstick) _____ Albumin _____ Sugar _____

VISION: Normal _____ Glasses _____ Contacts _____

HEARING: Normal _____ Abnormal _____ Explain _____

Check box:	N	Abn		N	Abn		N	Abn	
Growth development	<input type="checkbox"/>	<input type="checkbox"/>		Teeth	<input type="checkbox"/>	<input type="checkbox"/>	Genitalia	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>	Cardiopulmonary system	<input type="checkbox"/>	<input type="checkbox"/>		Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>
HEENT	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>		Neurobehavioral	<input type="checkbox"/>	<input type="checkbox"/>

Explain _____

LIMITATIONS

Activity restrictions _____

Diet restrictions _____

Signature _____ M.D./D.O./D.C./P.A./R.N.P.* Date _____

Address _____ Phone _____

City, State, ZIP _____

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INTERVAL RECORD	SCREENING EXAMINATION	
DATE, TIME, PLACE, ETC.	(Findings, diagnoses, treatment, instructions, disposition, etc.)	BY

TROOP

CAMP SITE

A PHOTOCOPY OF THIS FORM IS PERMITTED