

## Personal Health and the Annual Health and Medical Record



Find the current Annual Health and Medical Record by using this QR code or by visiting <http://www.scouting.org/HealthandSafety/ahmr.aspx>.

The Scouting adventure, camping trips, high-adventure excursions, and having fun are important to everyone in Scouting—and so are your safety and well-being. Completing the Annual Health and Medical Record is the first step in making sure you have a great Scouting experience. **So what do you need?**

**All Scouting Events.** All participants in all Scouting activities complete Part A and Part B. Give the completed forms to your unit leader. This applies to all activities, day camps, local tours, and weekend camping trips less than 72 hours. Update at least annually.

**Part A** is an informed consent, release agreement, and authorization that needs to be signed by every participant (or a parent and/or legal guardian for all youth under 18).

**Part B** is general information and a health history.

**Going to Camp?** A pre-participation physical is needed for resident, tour, or trek camps or for a Scouting event of more than 72 hours, such as Wood Badge and NYLT. The exam needs to be completed by a certified and licensed physician (MD, DO), nurse practitioner, or physician assistant. If your camp has provided you with any supplemental risk information, or if your plans include attending one of the four national high-adventure bases, share the venue's risk advisory with your medical provider when you are having your physical exam.

**Part C** is your pre-participation physical certification.

**Planning a High-Adventure Trip?** Each of the four national high-adventure bases has provided a supplemental risk advisory that explains in greater detail some of the risks inherent in that program. All high-adventure participants **must** read and share this information with their medical providers during their pre-participation physicals. Additional information regarding high-adventure activities may be obtained directly from the venue or your local council.

**Prescription Medication.** Taking 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 the BSA does not mandate or necessarily encourage the leader to do so. Standards and policies regarding administration of medication may be in place at BSA camps. If state laws are more limiting than camp policies, they must be followed. The AHMR also allows for a parent or guardian to authorize the administration of nonprescription medication to a youth by a camp health officer or unit leader, including any noted exceptions.

**Risk Factors.** Scouting activities can be physically and mentally demanding. Listed below are some of the risk factors that have been known to become issues during outdoor adventures.

- Excessive body weight (obesity)
- Cardiac or cardiovascular disease
- Hypertension (high blood pressure)
- Diabetes mellitus
- Seizures
- Asthma
- Sleep apnea
- Allergies or anaphylaxis
- Musculoskeletal injuries
- Psychological and emotional difficulties



More in-depth information about risk factors can be found by using this QR code or by visiting [http://www.scouting.org/HealthandSafety/risk\\_factors.aspx](http://www.scouting.org/HealthandSafety/risk_factors.aspx)

## Questions?

**Q. Why does the BSA require all participants to have an Annual Health and Medical Record?**

A. The AHMR serves many purposes. Completing a health history promotes health awareness, collects necessary data, and provides medical professionals critical information needed to treat a patient in the event of an illness or injury. It also provides emergency contact information.

Poor health and/or lack of awareness of risk factors have led to disabling injuries, illnesses, and even fatalities. Because we care about our participants' health and safety, the Boy Scouts of America has produced and required the use of standardized health and medical information since at least the 1930s.

The medical record is used to prepare for high-adventure activities and increased physical activity. In some cases, it is used to review participants' readiness for gatherings like the national Scout jamboree and other specialized activities.

Because many states regulate the camping industry, this Annual Health and Medical Record also serves as a tool that enables councils to operate day and resident camps and adhere to state and BSA requirements. The Boy Scouts of America Annual Health and Medical Record provides a standardized mechanism that can be used by members in all 50 states.



For answers to more questions, use this QR code or visit the FAQ page at [www.scouting.org/HealthandSafety/Resources/MedicalFormFAQs.aspx](http://www.scouting.org/HealthandSafety/Resources/MedicalFormFAQs.aspx).

**Download a free QR reader for your smartphone at [scan.mobi](http://scan.mobi).**



# Part A: Informed Consent, Release Agreement, and Authorization

**Full name:** \_\_\_\_\_  
**DOB:** \_\_\_\_\_

**High-adventure base participants:**  
Expedition/crew No.: \_\_\_\_\_  
or staff position: \_\_\_\_\_

Emergency Contact No.:

### Informed Consent, Release Agreement, and Authorization

I understand that participation in Scouting activities involves the risk of personal injury, including death, due to the physical, mental, and emotional challenges in the activities offered. Information about those activities may be obtained from the venue, activity coordinators, or your local council. I also understand that participation in these activities is entirely voluntary and requires participants to follow instructions and abide by all applicable rules and the standards of conduct.

In case of an emergency involving me or my child, I understand that efforts will be made to contact the individual listed as the emergency contact person by the medical provider and/or adult leader. 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 protected health information to the adult in charge, camp medical staff, camp management, and/or any physician or health-care provider involved in providing medical care to the participant. 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, includes 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.

(If applicable) I have carefully considered the risk involved and hereby give my informed consent for my child to participate in all activities offered in the program. I further authorize the sharing of the information on this form with any BSA volunteers or professionals who need to know of medical conditions that may require special consideration in conducting Scouting activities.

With appreciation of the dangers and risks associated with programs and activities, on my own behalf and/or on behalf of my child, I hereby fully and completely release and waive any and all claims for personal injury, death, or loss that may arise against the Boy Scouts of America, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with any program or activity.

I also hereby assign and grant to the local council and the Boy Scouts of America, as well as their authorized representatives, 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 further 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 BSA, and I specifically waive any right to any compensation I may have for any of the foregoing.



**NOTE: Due to the nature of programs and activities, the Boy Scouts of America and local councils cannot continually monitor compliance of program participants or any limitations imposed upon them by parents or medical providers. However, so that leaders can be as familiar as possible with any limitations, list any restrictions imposed on a child participant in connection with programs or activities below.**



List participant restrictions, if any:  None

\_\_\_\_\_

Allergies:

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. If I am participating at Philmont, Philmont Training Center, Northern Tier, Florida Sea Base, or the Summit Bechtel Reserve, I have also read and understand the supplemental risk advisories, including height and weight requirements and restrictions, and understand that the participant will not be allowed to participate in applicable high-adventure programs if those requirements are not met. The participant has permission to engage in all high-adventure activities described, except as specifically noted by me or the health-care provider. If the participant is under the age of 18, a parent or guardian's signature is required.

Participant's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/guardian signature for youth: \_\_\_\_\_ Date: \_\_\_\_\_  
**(If participant is under the age of 18)**

DOB:

Second parent/guardian signature for youth: \_\_\_\_\_ Date: \_\_\_\_\_  
**(If required; for example, California)**

### Complete this section for youth participants only:

#### Adults Authorized to Take to and From Events:

You must designate at least one adult. Please include a telephone number.

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Telephone: \_\_\_\_\_ Telephone: \_\_\_\_\_

#### Adults NOT Authorized to Take Youth To and From Events:

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Telephone: \_\_\_\_\_ Telephone: \_\_\_\_\_

Full Name:



**Prepared. For Life.®**

## Part B: General Information/Health History

**Full name:** \_\_\_\_\_

**High-adventure base participants:**

Expedition/crew No.: \_\_\_\_\_

or staff position: \_\_\_\_\_

**DOB:** \_\_\_\_\_

Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Height (inches): \_\_\_\_\_ Weight (lbs.): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP code: \_\_\_\_\_ Telephone: \_\_\_\_\_

Unit leader: \_\_\_\_\_ Mobile phone: \_\_\_\_\_

Council Name/No.: \_\_\_\_\_ Unit No.: \_\_\_\_\_

Health/Accident Insurance Company: \_\_\_\_\_ Policy No.: \_\_\_\_\_

Emergency Contact No.:



**Please attach a photocopy of both sides of the insurance card. If you do not have medical insurance, enter "none" above.**



**In case of emergency, notify the person below:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Home phone: \_\_\_\_\_ Other phone: \_\_\_\_\_

Alternate contact name: \_\_\_\_\_ Alternate's phone: \_\_\_\_\_

Allergies:

### Health History

Do you currently have or have you ever been treated for any of the following?

| Yes | No | Condition   | Explain  |
|-----|----|---|--|
|     |    | Diabetes  | Last HbA1c percentage and date:                                |
|     |    | Hypertension (high blood pressure)  |  |
|     |    | Adult or congenital heart disease/heart attack/chest pain (angina)/heart murmur/coronary artery disease. Any heart surgery or procedure. Explain all "yes" answers. |  |
|     |    | Family history of heart disease or any sudden heart-related death of a family member before age 50.   |  |
|     |    | Stroke/TIA  |  |
|     |    | Asthma  | Last attack date:  |
|     |    | Lung/respiratory disease  |  |
|     |    | COPD  |  |
|     |    | Ear/eyes/nose/sinus problems  |  |
|     |    | Muscular/skeletal condition/muscle or bone issues   |  |
|     |    | Head injury/concussion  |  |
|     |    | Altitude sickness   |  |
|     |    | Psychiatric/psychological or emotional difficulties   |  |
|     |    | Behavioral/neurological disorders   |  |
|     |    | Blood disorders/sickle cell disease   |  |
|     |    | Fainting spells and dizziness   |  |
|     |    | Kidney disease  |  |
|     |    | Seizures  | Last seizure date:   |
|     |    | Abdominal/stomach/digestive problems  |  |
|     |    | Thyroid disease   |  |
|     |    | Excessive fatigue   |  |
|     |    | Obstructive sleep apnea/sleep disorders   | CPAP: Yes <input type="checkbox"/> No <input type="checkbox"/> |
|     |    | List all surgeries and hospitalizations   | Last surgery date:   |
|     |    | List any other medical conditions not covered above   |  |

DOB:

Full Name:



## Part B: General Information/Health History

Full name: \_\_\_\_\_  
 DOB: \_\_\_\_\_

**High-adventure base participants:**  
 Expedition/crew No.: \_\_\_\_\_  
 or staff position: \_\_\_\_\_

### Allergies/Medications

Are you allergic to or do you have any adverse reaction to any of the following?

| Yes | No | Allergies or Reactions | Explain | Yes | No | Allergies or Reactions | Explain |
|-----|----|------------------------|---------|-----|----|------------------------|---------|
|     |    | Medication             |         |     |    | Plants                 |         |
|     |    | Food                   |         |     |    | Insect bites/stings    |         |

List all medications currently used, including any over-the-counter medications.

CHECK HERE IF NO MEDICATIONS ARE ROUTINELY TAKEN.  IF ADDITIONAL SPACE IS NEEDED, PLEASE INDICATE ON A SEPARATE SHEET AND ATTACH.

| Medication | Dose | Frequency | Reason |
|------------|------|-----------|--------|
|            |      |           |        |
|            |      |           |        |
|            |      |           |        |
|            |      |           |        |
|            |      |           |        |
|            |      |           |        |

YES  NO Non-prescription medication administration is authorized with these exceptions: \_\_\_\_\_

Administration of the above medications is approved for youth by:

\_\_\_\_\_/\_\_\_\_\_  
 Parent/guardian signature MD/DO, NP, or PA signature (if your state requires signature)

**Bring enough medications in sufficient quantities and in the original containers. Make sure that they are NOT expired, including inhalers and EpiPens. You SHOULD NOT STOP taking any maintenance medication unless instructed to do so by your doctor.**

### Immunization

The following immunizations are recommended by the BSA. Tetanus immunization is required and must have been received within the last 10 years. If you had the disease, check the disease column and list the date. If immunized, check yes and provide the year received.

| Yes | No | Had Disease | Immunization                               | Date(s) |
|-----|----|-------------|--|---------|
|     |    |             | Tetanus                                    |         |
|     |    |             | Pertussis                                  |         |
|     |    |             | Diphtheria                                 |         |
|     |    |             | Measles/mumps/rubella                      |         |
|     |    |             | Polio                                      |         |
|     |    |             | Chicken Pox                                |         |
|     |    |             | Hepatitis A                                |         |
|     |    |             | Hepatitis B                                |         |
|     |    |             | Meningitis                                 |         |
|     |    |             | Influenza                                  |         |
|     |    |             | Other (i.e., HIB)                          |         |
|     |    |             | Exemption to immunizations (form required) |         |

Please list any additional information about your medical history:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**DO NOT WRITE IN THIS BOX**

Review for camp or special activity.

Reviewed by: \_\_\_\_\_

Date: \_\_\_\_\_

Further approval required:  Yes  No

Reason: \_\_\_\_\_

Approved by: \_\_\_\_\_

Date: \_\_\_\_\_



Emergency Contact No.:

Allergies:

DOB:

Full Name:

## Part C: Pre-Participation Physical

This part must be completed by certified and licensed physicians (MD, DO), nurse practitioners, or physician assistants.

Full name: \_\_\_\_\_

DOB: \_\_\_\_\_

**High-adventure base participants:**

Expedition/crew No.: \_\_\_\_\_  
or staff position: \_\_\_\_\_

Emergency Contact No.:



**You are being asked to certify that this individual has no contraindication for participation inside a Scouting experience. For individuals who will be attending a high-adventure program, including one of the national high-adventure bases, please refer to the supplemental information on the following pages or the form provided by your patient.**



**Examiner: Please fill in the following information:**

|                                     |    | Yes                    | No | Explain |  |     |    |                        |  |         |  |
|-------------------------------------|----|------------------------|----|---------|--|-----|----|------------------------|--|---------|--|
| Medical restrictions to participate |    |                        |    |         |  |     |    |                        |  |         |  |
| Yes                                 | No | Allergies or Reactions |    | Explain |  | Yes | No | Allergies or Reactions |  | Explain |  |
|                                     |    | Medication             |    |         |  |     |    | Plants                 |  |         |  |
|                                     |    | Food                   |    |         |  |     |    | Insect bites/stings    |  |         |  |

Height (inches): \_\_\_\_\_ Weight (lbs.): \_\_\_\_\_ BMI: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ / \_\_\_\_\_ Pulse: \_\_\_\_\_

Allergies:

|                  | Normal | Abnormal | Explain Abnormalities |
|------------------|--------|----------|-----------------------|
| Eyes             |        |          |                       |
| Ears/nose/throat |        |          |                       |
| Lungs            |        |          |                       |
| Heart            |        |          |                       |
| Abdomen          |        |          |                       |
| Genitalia/hernia |        |          |                       |
| Musculoskeletal  |        |          |                       |
| Neurological     |        |          |                       |
| Other            |        |          |                       |

DOB:

### Examiner's Certification

I certify that I have reviewed the health history and examined this person and find no contraindications for participation in a Scouting experience. This participant (with noted restrictions):

| True | False | Explain   |
|------|-------|---|
|      |       | Meets height/weight requirements.   |
|      |       | Does not have uncontrolled heart disease, asthma, or hypertension.  |
|      |       | Has not had an orthopedic injury, musculoskeletal problems, or orthopedic surgery in the last six months or possesses a letter of clearance from his or her orthopedic surgeon or treating physician. |
|      |       | Has no uncontrolled psychiatric disorders.  |
|      |       | Has had no seizures in the last year.   |
|      |       | Does not have poorly controlled diabetes.   |
|      |       | If less than 18 years of age and planning to scuba dive, does not have diabetes, asthma, or seizures.   |
|      |       | <b>For high-adventure participants, I have reviewed with them the important supplemental risk advisory provided.</b>  |

Examiner's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Provider printed name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP code: \_\_\_\_\_

Office phone: \_\_\_\_\_

**Height/Weight Restrictions**

If you exceed the maximum weight for height as explained in the following chart and your planned high-adventure activity will take you more than 30 minutes away from an emergency vehicle/accessible roadway, you may not be allowed to participate.

**Maximum weight for height:**

| Height (inches) | Max. Weight | Height (inches) | Max. Weight | Height (inches) | Max. Weight | Height (inches) | Max. Weight |
|-----------------|-------------|-----------------|-------------|-----------------|-------------|-----------------|-------------|
| 60              | 166         | 65              | 195         | 70              | 226         | 75              | 260         |
| 61              | 172         | 66              | 201         | 71              | 233         | 76              | 267         |
| 62              | 178         | 67              | 207         | 72              | 239         | 77              | 274         |
| 63              | 183         | 68              | 214         | 73              | 246         | 78              | 281         |
| 64              | 189         | 69              | 220         | 74              | 252         | 79 and over     | 295         |

Full Name:



**Prepared. For Life.®**

## Part D: Connecticut Rivers Council Addendum

|  |                        |
|--|------------------------|
| Full Name: _____   | Dates Attending: _____ |
| Campsite: _____  | Unit: _____            |
| <input type="checkbox"/> Scout <input type="checkbox"/> Scouter <input type="checkbox"/> Staff |                        |

This addendum to the Annual BSA Health and Medical Records is for youths and adults who are participating in a CRC camp program. This is required to meet Connecticut Department of Public Health requirements. Please read and sign the form at the bottom of the page.

**If you disagree with any statements here, please cross out that section and initial it. Explain your wishes in the comment section, attaching an additional sheet if necessary.**

- This medical form is correct so far as I know, and the person named in Part A has permission to **participate in all camp activities** except as noted on the form by me or by the doctor in Part C.
- I hereby request that the camp's Health Officer administer the **prescription and/or over-the-counter medication(s)** ordered by my child's doctor/dentist. I understand that I must supply the camp with the prescribed medication in the original container as dispensed and properly labeled by a doctor or a pharmacist and will provide no more than is appropriate for my child's camp stay. I understand that this medication will be destroyed if not picked up within one week after my child leaves camp.
- I also give permission for my child to **participate in trips** sponsored by the camp and approved by the adult/unit leader in charge. Examples of these trips are whitewater merit badge, orienteering merit badges, or trips for rock climbing or mountain biking.
- I give my permission for the Camp Health Officer to administer over-the-counter medications as directed for conditions as directed by the Camp Physician. Over-the-counter medications may include **WOUNDS:** Hydrogen Peroxide, Neosporin, Bacitracin **POISON IVY:** Tecnu, Benadryl cream **CANKER SORES:** Benzocaine cream **PAIN:** Tylenol, Ibuprofen **DYSMENORRHEA:** Ibuprofen **ABDOMINAL DISCOMFORT:** Tums, Maalox **HEADACHE:** Tylenol, Ibuprofen **HYPOGLYCEMIA:** Glucose Gel, Glucagon **ALLERGIC REACTION:** Benadryl or generic, Epipen **ATHLETE'S FOOT:** Tinactin **INSECT STING/BITE:** Benadryl Cream, Hydrocortisone cream, Caladryl or Calagel, Epipen **TICK BITES:** Alcohol or Hydrogen Peroxide **1<sup>st</sup> DEGREE BURNS:** Burn Jel, Aloe Spray **EMERGENCIES:** Oxygen. Generics may be substituted.

**This section must be signed to indicate acceptance of conditions above.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 (Adults over 18 sign here. Parent/Guardian signs for camper.)

Name (print): \_\_\_\_\_ Relationship: \_\_\_\_\_

Comments:

Emergency Contact No.:

Allergies:

DOB:

Full Name: