

# Annual BSA Health and Medical Record – Health History

## 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. \_\_\_\_\_

**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 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"/>	Chickenpox _____
<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.

**(For more information about immunizations, as well as Immunization exemption form, see Scouting Safely on [www.scouting.org](http://www.scouting.org).)**

## 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.

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.

Unit Number #:

Allergies:

DOB:

Last name:

## Informed Consent and Hold Harmless/Release Agreement

I understand that participation in Scouting activities involved 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 examination findings, test results, and treatment provide 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) \_\_\_\_\_

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## Talent Release Form

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 recording made of me or my child by the Boy Scouts of America, and I hereby release the Boy Scouts of America from any and all liability from such use and publication.

I 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

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## Lyme disease – Be wary, not worried, when enjoying the outdoors!

Lyme disease is becoming increasingly common in Minnesota, Wisconsin and other states. Lyme disease is spread by the bite of certain ticks. It is important for people who work or recreate outdoors to learn the facts about the disease and to prevent it. By taking some simple precautions and knowing the symptoms of the disease, we can continue to safely enjoy the pleasures and benefits of the outdoors. The links below will help Scouters stay safe while enjoying the woods. [www.stopticks.org](http://www.stopticks.org); [www.lymediseaseassociation.com](http://www.lymediseaseassociation.com); and [www.ilads.org](http://www.ilads.org) I have read and understand this.

Yes  No

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## Permission to Participate in Shooting Sports for all Cub Scouts, Boy Scouts, Venturers and Explorers:

I, \_\_\_\_\_ (print your name) grant my consent to Northern Star Council and to its representatives including Range Officers and Instructors and others serving in these positions to furnish my child with BB guns or firearms and ammunition and provide instruction as to their use. I further certify that I am the parent with full parental rights or the legal guardian of this child. I understand that this document will be kept and maintained by the Northern Star Council or its representatives including Range Officers and Instructors. I further understand that any modification of this form will result in it's not being accepted by Northern Star Council, Range Officers and Instructors.

Signature of Parent or Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

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I have read and understand all the information shared in this form. 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 \_\_\_\_\_

Last Name: \_\_\_\_\_ DOB: \_\_\_\_\_