



# Treasure Valley Scout Reservation Medical Form

## For All Boy Scout, Cub Scout & Venture Activities

Mohegan Council, Boy Scouts of America



\*\*\*Meets All BSA Health and Medical Record Class 3 Requirements\*\*\*

This Health and Medical Record is required for participation in resident camp at Treasure Valley Scout Reservation. Each participant at Treasure Valley is subject to medical recheck. Treasure Valley recognizes the right to a Scout not to have immunizations etc. because of religious beliefs; however, a statement signed by the parents is required, indicating that the Scout is free from contagious disease and is able to physically tolerate camping at Treasure Valley. Write to Mohegan Council, 19 Harvard Street, Worcester, MA 01609 for a copy of the statement required.

**IMPORTANT** – The participant must provide a **CURRENT** health history, a **CURRENT** immunization record, and a report of a physical examination conducted during the preceding 24 months (CMR 430.151 (A-2). **Adults 40 years of age or over must show evidence of physical exam within the past 12 months** (BSA National Standards).

### DIRECTIONS –

1. **Parents/guardians must complete pages 1,2,4,5 & 6**
2. This form is to be renewed yearly by parent/guardian
3. Physician's Office completes & verifies immunizations history and SIGNS WHERE INDICATED – OR – attached signed report of physical examination conducted during the preceding 24 months (**for persons 40 years of age or over, within the preceding 12 months**).
4. **Participant (or parent / guardian of participant under 18 years of age) SIGNS in all areas indicated.**
5. DO NOT mail this form anywhere!!! Bring it to camp and to the medical recheck.

### PER STATE AND BSA REGULATIONS:

**FAILURE TO  
PROPERLY  
COMPLETE THIS  
FORM WILL  
RESULT IN THE  
INDIVIDUAL  
NOT BEING  
ADMITTED TO  
CAMP.**

**IDENTIFYING INFORMATION** – To be completed by Parent or Participants 18 years of age or older.

NAME: \_\_\_\_\_ UNIT # \_\_\_\_\_ DOB: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

**IN THE EVENT OF EMERGENCY, PLEASE NOTIFY** (give full names, area codes, and telephone numbers)

Mother: \_\_\_\_\_ Home Tel: \_\_\_\_\_ Work Tel: \_\_\_\_\_ Mobile: \_\_\_\_\_

Father: \_\_\_\_\_ Home Tel: \_\_\_\_\_ Work Tel: \_\_\_\_\_ Mobile: \_\_\_\_\_

Please notify both parents. In the event that neither parent can be reached, or for adult participant, call:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Home Tel: \_\_\_\_\_ Work Tel: \_\_\_\_\_

Parents' vacation address, if any: \_\_\_\_\_ Telephone: \_\_\_\_\_

Insurance Co. or HMO: \_\_\_\_\_ Policy #: \_\_\_\_\_

Insurance Co. or HMO address: \_\_\_\_\_ City and State: \_\_\_\_\_ Zip: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ City & State: \_\_\_\_\_ Tel: \_\_\_\_\_

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Please fill out this page completely

## EMERGENCY INFORMATION / HEALTH HISTORY / INCLUDING ALL ALLERGIES

- To be completed by Parent or Participants 18 years of age or older.

ARE THE PARENT / PARTICIPANT AWARE OF ANY CURRENT HEALTH PROBLEMS?  No  Yes

Details: \_\_\_\_\_

IS THE PARTICIPANT UNDER MEDICAL CARE FOR ANY REASON?  No  Yes

Details: \_\_\_\_\_

HAS THERE BEEN ANY SURGERY, INJURY, ILLNESS, ALLERGY, OR CHANGE IN HEALTH STATUS SINCE LAST COMPLETE PHYSICAL EXAMINATION?  No  Yes Detail: \_\_\_\_\_

IS THERE DISEASE OF, OR PAST OR PRESENT HISTORY OF:

Serious illness	<input type="checkbox"/> No <input type="checkbox"/> Yes	Bridge	<input type="checkbox"/> No <input type="checkbox"/> Yes	Sugar	<input type="checkbox"/> No <input type="checkbox"/> Yes
Serious injury	<input type="checkbox"/> No <input type="checkbox"/> Yes	Chest, Lungs	<input type="checkbox"/> No <input type="checkbox"/> Yes	Infection	<input type="checkbox"/> No <input type="checkbox"/> Yes
Deformity	<input type="checkbox"/> No <input type="checkbox"/> Yes	Heart	<input type="checkbox"/> No <input type="checkbox"/> Yes	Bed wetting	<input type="checkbox"/> No <input type="checkbox"/> Yes
Surgery	<input type="checkbox"/> No <input type="checkbox"/> Yes	Murmur	<input type="checkbox"/> No <input type="checkbox"/> Yes	Menstrual	<input type="checkbox"/> No <input type="checkbox"/> Yes
Skin, Glands	<input type="checkbox"/> No <input type="checkbox"/> Yes	Rheumatic fever	<input type="checkbox"/> No <input type="checkbox"/> Yes	Hernia	<input type="checkbox"/> No <input type="checkbox"/> Yes
Ears, Eyes	<input type="checkbox"/> No <input type="checkbox"/> Yes	Stomach, Bowels	<input type="checkbox"/> No <input type="checkbox"/> Yes	Back, Limbs	<input type="checkbox"/> No <input type="checkbox"/> Yes
Nose, Sinus	<input type="checkbox"/> No <input type="checkbox"/> Yes	Appendicitis	<input type="checkbox"/> No <input type="checkbox"/> Yes	Sleepwalking	<input type="checkbox"/> No <input type="checkbox"/> Yes
Teeth, Tonsils	<input type="checkbox"/> No <input type="checkbox"/> Yes	Kidneys, Urine	<input type="checkbox"/> No <input type="checkbox"/> Yes	Nervousness	<input type="checkbox"/> No <input type="checkbox"/> Yes
Dentures	<input type="checkbox"/> No <input type="checkbox"/> Yes	Albumin	<input type="checkbox"/> No <input type="checkbox"/> Yes	Tuberculosis	<input type="checkbox"/> No <input type="checkbox"/> Yes

Details: \_\_\_\_\_

PARTICIPANT HAS OR IS SUBJECT TO THE FOLLOWING (give details for any checked):

Allergy to a medicine, food, plant or insect toxin: \_\_\_\_\_

Any condition that may require special care, medication, or diet: \_\_\_\_\_

ADHD (Attention Deficit Hyperactivity Disorder)

Asthma  Contact Lenses  Dentures  Fainting Spells

Bleeding  Convulsions  Diabetes  Heart Trouble

Details: \_\_\_\_\_

## MEDICATIONS – To be completed by Parent or Participants 18 years of age or older.

**IF PARTICIPANT IS UNDER 18 YEARS OF AGE:**

Is the participant bringing any medications (prescriptions or over the counter) to camp?  Yes  No.  
If yes, please complete the Authorization to Administer Medication to a Camper or Staff Member less than 18 years of age section on page 4 & 5 of this packet.

**IF PARTICIPANT IS 18 YEARS OF AGE OR OLDER:**

Is the participant bringing any medications to camp?  Yes  No

If yes, list medications: \_\_\_\_\_

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**This page to be filled out Physician's office & signed where indicated**

**IMMUNIZATIONS** – Per Massachusetts State regulations, Must be varified by Physician's Office.

Has the participant had chicken pox? \_\_\_ No \_\_\_ Yes

Has the participant had chicken pox vaccine? \_\_\_ No \_\_\_ Yes

**FOR CAMPERS AND STAFF UNDER 18 YEARS OLD** – (please indicate dates on lines below)

MMR        Dose 1 \_\_\_\_\_ Dose 2 \_\_\_\_\_

Polio        Dose 1 \_\_\_\_\_ Dose 2 \_\_\_\_\_ Dose 3 \_\_\_\_\_ Dose 4 \_\_\_\_\_

DTP        Dose 1 \_\_\_\_\_ Dose 2 \_\_\_\_\_ Dose 3 \_\_\_\_\_ Dose 4 \_\_\_\_\_

Hepatitis B required for all children born on or after January 1, 1992. Dose 1 \_\_\_\_\_

**FOR CAMPERS AND STAFF 18 YEARS OLD AND OLDER** – (please indicate dates on lines below)

Measles: Born before 1957 \_\_\_\_\_, or Laboratory evidence of immunity \_\_\_\_\_, Dose 1 \_\_\_\_\_ Dose 2 \_\_\_\_\_

Mumps: Born before 1957 \_\_\_\_\_, or Laboratory evidence of immunity \_\_\_\_\_, Dose 1 \_\_\_\_\_

Rubella: Laboratory evidence of immunity \_\_\_\_\_, Dose 1 \_\_\_\_\_

Diphtheria and Tetanus Toxoids\*: Polio        Dose 1 \_\_\_\_\_ Dose 2 \_\_\_\_\_ Dose 3 \_\_\_\_\_

\*A booster dose of tetanus, diphtheria, adult type toxaid (Td) is required if more than 10 years have passed since the last one.

**Physician's Office Verification:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**PHYSICAL EXAMINATION** – To be completed by LICENSED HEALTH CARE PROVIDER

                  Height \_\_\_\_\_        Weight \_\_\_\_\_        B.P. \_\_\_\_\_/\_\_\_\_\_        Pulse \_\_\_\_\_

Vision:        Normal \_\_\_\_\_        Glasses \_\_\_\_\_        Contacts \_\_\_\_\_

Hearing:        Normal \_\_\_\_\_        Abnormal \_\_\_\_\_        Hearing Aide \_\_\_\_\_

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

**APPROVED FOR PARTICIPATION IN:**

\_\_\_ Hiking and camping        \_\_\_ Water activities        \_\_\_ Competitive sports        \_\_\_ All activities

Specify exceptions: \_\_\_\_\_

Recommendations (explain any restrictions OR limitations): \_\_\_\_\_

**Physician's Verification:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Health Care Practitioner Licensed to Perform Physical Examination's Information:**

**Telephone:** \_\_\_\_\_ **Address:** \_\_\_\_\_

# Treasure Valley Scout Reservation Medical Form (page 4)

**AUTHORIZATION TO ADMINISTER MEDICATION TO A CAMPER OR STAFF UNDER 18 YEARS OF AGE – To be completed by parent or legal guardian.**

Parents/guardians requesting medication administration to their child from camp staff shall provide the camp health staff with appropriate written authorization(s) and the medication before any medications are administered. Medications must be in the original container and labeled with the child's name, name of medication, directions for medication's administration, and date of the prescription. All unused medication will be destroyed within one week following the camper's departure at the end of camp.

**Authorized Prescriber's Order (Physician, Dentist, Physician Assistant, Advanced Practice Registered Nurse):**

Name of Child \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_ Date \_\_\_/\_\_\_/2008  
Medication Name \_\_\_\_\_ Controlled Drugs yes \_\_\_ No \_\_\_  
Dosage \_\_\_\_\_ Route \_\_\_\_\_ Time of Administration \_\_\_\_\_  
Specific Instructions for Medication Administration \_\_\_\_\_  
Medication Administration: Start Date \_\_\_/\_\_\_/\_\_\_ Stop Date \_\_\_/\_\_\_/\_\_\_  
Relevant Side Effects of Medication \_\_\_\_\_  
Plan of Management for SideEffects \_\_\_\_\_  
Known Food or Drug Allergies: Yes \_\_\_ No \_\_\_ Reactions to? Yes \_\_\_ No \_\_\_ Interactions with? Yes \_\_\_ No \_\_\_  
If "yes" to any of the above, please explain \_\_\_\_\_

**\*This medication is an emergency medication and NOT a controlled substance, and the camper is authorized to**

**Carry and self-administer the above prescribed medication: Yes \_\_\_ No \_\_\_**

Prescriber's Name \_\_\_\_\_  
Prescriber's Address \_\_\_\_\_  
Phone Number (\_\_\_\_\_) \_\_\_\_\_ Fax Number (\_\_\_\_\_) \_\_\_\_\_  
Prescriber's Signature \_\_\_\_\_ Use for Prescriber's Stamp

**Parent/Guardian Authorization:**

I request that medication be administered to my child as described and directed above, and agree to Provide the camp with the medication's in a quantity Appropriate for my child's stay at camp. if applicable, I authorize my child to carry and self-administer the above-prescribed **emergency** medication. Yes \_\_\_ No \_\_\_

Parent/guardian Signature \_\_\_\_\_ Relationship to Child \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

**Camper Agreement (only for emergency medications to be self-carried and administered):**

I have been trained and understand how and when to use my medications. I accept the responsibility to Carry my medication with me at all times, to not share it with anyone else, and to inform the camp health Staff when I have used it.

Camper Signature \_\_\_\_\_

Signature of Camp Personnel receiving Written Authorization and Medication \_\_\_\_\_

Title/Position \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

# Treasure Valley Scout Reservation Medical Form (page 5)

**AUTHORIZATION TO ADMINISTER OVER THE COUNTER MEDICATION TO A CAMPER OR STAFF UNDER 18 YEARS OF AGE** – To be completed by parent or legal guardian.

**Over the counter Medication Description Form**

This summer we are asking all campers who will be taking any OTC medication's while at camp to complete an **OTC Medication Description Form**. Please enclose all medications (enough for the week your scout is at camp) in a sealed bag with the scouts name, campsite & troop number on it along with the completed Medication Description Form and send this with your scout to camp to be given to the camp medical officer at medical check in.

**Please note; All over the counter medications are to be in their original packaging not expired, or we will be unable to administer that medication to your child.**

*The information on this form is correct and complete. I hereby give my permission for Treasure Valley Scout Reservation medical staff to administer the medication as directed.*

\_\_\_\_\_ Relation to camper \_\_\_\_\_ Date \_\_\_ / \_\_\_ / 2008

Parent/guardian signature

**Camper's name:** \_\_\_\_\_ **troop number** \_\_\_\_\_

Allergies: \_\_\_\_\_

Medication name	given at	dose	special instructions
	Breakfast		
	Lunch		
	Supper		
	Bedtime		

Any special instructions:

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# Treasure Valley Scout Reservation Medical Form (page 6)<sub>1/2008</sub>

Unit leaders & parents/guardians please sign where indicated

## PARENTAL STATEMENT AND TALENT RELEASE – Parent or Participant over 18 please read and sign.

I, the undersigned, have read and understood this entire form. The information provided herein is accurate and complete. The person described herein has permission for the full participation in the BSA programs, subject to any limitations noted herein. In the event of illness or accident in the course of such activity, I hereby request that measures be instituted without delay as the judgment of medical personnel dictates. These measures may include but are not limited to treatment in camp, transportation to and out-of camp medical facility, treatment at such facility, and any outside physician, hospital, or treatment facility to release and exchange any and all information connected with treatment.

I hereby assign and grant to the Boy Scouts of America the right and permission to use and publish any photographs/film/video tapes/electronic representations and/or sound recordings 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 hereby authorize the reproduction, sale, copyright, exhibit, broadcast, electronic storage and/or distribution of said photographs/film/video tapes/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 (or my child) may have for any of the foregoing.

*Note: Once submitted, this form becomes the property of Treasure Valley Scout Reservation. Parents, participants, and / or Troop Leaders who need extra copies are urged to make them prior to coming to camp.*

**Participant's Signature** (if 18 or older): \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent's Signature** (if participant is under 18): \_\_\_\_\_ **Date:** \_\_\_\_\_



### \*\*\*TROOP LEADER AND CAMP SCREENING\*\*\*

**Reviewed by Unit Leader** (print) \_\_\_\_\_ Position \_\_\_\_\_

Signature \_\_\_\_\_ Date / / 2008

Screened at Camp by \_\_\_\_\_ OK'd \_\_\_\_\_ Date \_\_\_\_\_

Notes: \_\_\_\_\_

Screened at Camp by \_\_\_\_\_ OK'd \_\_\_\_\_ Date \_\_\_\_\_

Notes: \_\_\_\_\_

Additional Comments: \_\_\_\_\_