

CHIEF OKEMOS COUNCIL BOY SCOUTS OF AMERICA
 (FOR USE BY ALL ADULT CAMPERS) Please print or type

Name _____ Age _____
 Address _____ City _____ State _____ Zip _____
 Council _____ Unit #. _____ Pack Troop Crew

IN CASE OF EMERGENCY PLEASE NOTIFY:

Name _____ Relationship _____
 Address _____ City _____ State _____ Zip _____
 Home Phone _____ Other Phone _____

Health History

Indicate any of the following that you have had or currently have:

- | | | |
|--|--|--|
| <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting Spells |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Earache/Ear Infection |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Heart Trouble |
| <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Menstrual Problems | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Stinging Insect Reaction | <input type="checkbox"/> Severe Stomach Pain |
| <input type="checkbox"/> Infectious Diseases | <input type="checkbox"/> Other Allergies or Reactions to Any Medications, Please | |

Explain: _____ Specify _____

PLEASE PROVIDE THE FOLLOWING INFORMATION

- Yes No Do you tire easily?
 Yes No Do you get out of breath easily?
 Yes No Have you had more than a brief minor illness or injury during the past year?
 Yes No Do you have any condition now requiring regular medication or treatment?
 Yes No Have you had any surgeries or serious injuries? If yes, please describe * give date below.
 Yes No Do you have any restriction of activity for medical reasons?
 Yes No Are you currently taking any medication prescribed by a doctor?
 Yes No Are there behavior considerations which need to be considered?
 Yes No Are there any special health considerations?

Please provide additional information for any above question(s) answered
 yes _____

Please Provide Immunization Record And Date Of Last Inoculation.

Smallpox ___/___/___	Diphtheria ___/___/___	Whooping Cough ___/___/___
Tetanus ___/___/___	Typhoid ___/___/___	Poliomyelitis ___/___/___
Mumps ___/___/___	Measles ___/___/___	Chicken Pox ___/___/___
Rubella ___/___/___	Other, Specify _____	

The health history contained herein is correct so far as I know, and I understand that I assume all liability for my engaging in camp activities and am able to engage in all camp activities, except as noted by the physician and me. I hereby give permission to the physician selected by a designated representative of the Boy Scouts of America to authorize emergency medical or surgical treatment, routine, non-surgical medical care, hospitalize, secure proper anesthesia, or to order injection(s) for me if I am unable to respond due to injury or illness. Otherwise, I assume the health responsibility for myself.

Date: _____ Signature: _____ Valid for one year from date signed

TO BE COMPLETED BY A LICENSED PHYSICIAN Name _____

NOTE TO LICENSED HEALTH-CARE PRACTITIONERS: The person being evaluated will be attending one 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 history with the participant for any interim changes. **Please explain any "abnormal" evaluations.**

PHYSICAL EXAMINATION (To be filled out by a licensed health-care practitioner*)

Height _____ Weight _____ BP _____ / _____ Pulse _____

Lab: Urinalysis (dipstick) Normal _____ Albumin _____ Sugar _____

VISION: Normal _____ Glasses _____ Contacts _____

HEARING: Normal _____ Abnormal _____ Explain _____

Check Box:

	N	Abn
Growth, Development		
Cardiopulmonary System		
Neurobehavior		
Head, Neck, Thyroid		

	N	Abn
Musculoskeletal		
Genitalia		
Teeth, Tonsils		
Eyes, Ears, Nose		

	N	Abn
Skin, Glands, Hair		
HEENT		
Hernia, Abdomen		
Respiratory		

Explain (if necessary): _____

Limitations:

Activity Restrictions: _____

Diet Restrictions _____

Signature _____ Date _____
Licensed Health Care Practitioner

Address: _____ Phone _____

City, State, Zip _____

*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.

The Boy Scouts of America requires a physical examination for all campers and adults who are under the age of forty, within 36 months prior to attendance at a summer camp. Adults over forty must have a physical examination within the twelve months preceding their attendance at a summer camp.

INTERVAL RECORD SCREENING EXAMINATION

Date, time, place findings, diagnoses, treatment(s), instructions, disposition by:

Applicant's Signature _____ Date _____

Name of personal Physician (please print) _____ Phone _____

Personal health/accident insurance provider _____

Policy number _____

Photocopying of this form is permitted

ADULT VOLUNTEER FORM

(To be filled in by all adults staying in camp Please Print)

Name _____ Unit _____

Are you registered with the Boy Scout of America? NO YES

If yes, please give registered position: _____

Unit position held while in camp: _____

Number of years as an adult in camp _____

Please indicate training received (I = date issued, E = date expires):

	E		I		I
Water Safety Instructor		BSA National Camp School		ARC Advanced Swimmer	
ARC Life Guard Instructor		Life Saving Merit Badge		BSA Basic Adult Leader Training	
ARC Life Guard		CPR-BLS Certified		Safe Swim Defense Training	
		ARC First Aid		Woodbadge	
		BSA Life Guard		ARC Basic Water Safety	

REFERENCES

Please provide the names of two individuals not related to you:

Name: _____ Relationship: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Name: _____ Relationship: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Have you ever been convicted of anything other than a minor traffic violation? YES NO

If yes please explain:

The information contained in this form is correct to the best of my knowledge.

Signed: _____ Date: _____