

**HEALTH AND MEDICAL RECORD**  
**CHIEF OKEMOS COUNCIL BOY SCOUTS OF AMERICA**  
(FOR USE BY ALL YOUTH CAMPER(S)) **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 Disease | <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 the person herein described has permission to engage in all prescribed activities, except as noted by the physician and me. In the event I cannot be reached in an emergency, 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 my son (or daughter). The person herein described is in good health, has all required immunizations current, and I assume the health responsibility for the individual.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_ Valid for one year from date signed  
Date: \_\_\_\_\_ Signature: \_\_\_\_\_ Valid for one year from date signed  
Date: \_\_\_\_\_ Signature: \_\_\_\_\_ Valid for one year from date signed

Signature(s) of parent(s) or guardian(s)

**CAMP PHYSICAL FORM**

**Camper's 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. **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		N	Abn		N	Abn
Growth, Development			Musculoskeletal			Skin, Glands, Hair		
Cardiopulmonary System			Genitalia			HEENT		
Neurobehavior			Teeth, Tonsils			Hernia, Abdomen		
Head, Neck, Thyroid			Eyes, Ears, Nose			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**

# Camper Release Form

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

Council \_\_\_\_\_ Unit #. \_\_\_\_\_  Pack  Troop  Crew

Authorization is granted for the release of the aforementioned individual to employees, Council Staff, registered volunteers of the Unit, and Camp Staff of Chief Okemos Council, Boy Scouts of America. In addition, only those individuals listed below are authorized to remove the aforementioned individual from Summer Camp during his/her period of camping: \*

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

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

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

The following authorization is required by the Michigan Department of Consumers & Industry Services, pursuant to Rule 400.11117 (3-1, 2, 2b, 2c).

1. All Campers are to be released to an authorized person.
2. Authorized persons are directed to the Health Lodge to sign his/her camper out. The sign-out log must be filled out with the Camper's name, the date and time of check-out, and the authorized person's signature. This may require a photo and/or signature identification.
3. When a custodial parent requests that a Camper not be signed out to a non-custodial parent, such request must be in writing.
4. When a last-minute change occurs as to the individual who will be picking up a Camper, the new instructions will be double-checked by the Health Officer or designee. This may include a request to see a photo identification, a verification phone contact, and/or a signature check.
5. Under no circumstances is a Camper to be dropped off and left alone. Every effort shall be made to contact the authorized person. If unsuccessful at contacting the authorized person, the Camper is to stay with the Unit Leader until said person can be contacted.
6. At the end of the Unit's stay at Northwoods Scout Reservation, and after all medical forms have been returned to the Unit Leader, the Unit Leader assumes all responsibility for the Campers.

**\* Please Note: If both parents have not signed this form in the space provided below, please list the unsigned Spouse on one of the lines provided above.**

Signature \_\_\_\_\_ Date \_\_\_\_\_  
Parent or Guardian

Signature \_\_\_\_\_ Date \_\_\_\_\_  
Parent or Guardian

**VALID FOR ONE YEAR FROM THE DATE SIGNED ABOVE**