

Full name: _____

Date of birth: _____

High-adventure base participants:

Expedition/crew No.: _____
or staff position: _____

Age: _____ Gender: _____ Height (inches): _____ Weight (lbs.): _____

Address: _____

City: _____ State: _____ ZIP code: _____ Phone: _____

Unit leader: _____ Unit leader's mobile #: _____

Council Name/No.: _____ Unit No.: _____

Health/Accident Insurance Company: _____ Policy 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: _____

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: _____ Insulin pump: Yes <input type="checkbox"/> No <input type="checkbox"/>
		Hypertension (high blood pressure)	
		Adult or congenital heart disease/heart attack/chest pain (anginal)/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/reactive airway disease	Last attack date: _____
		Lung/respiratory disease	
		COPD	
		Ear/eyes/nose/sinus problems	
		Muscular/skeletal condition/muscle or bone issues	
		Head injury/concussion/TBI	
		Altitude sickness	
		Psychiatric/psychological or emotional difficulties	
		Neurological/behavioral disorders	
		Blood disorders/sickle cell disease	
		Fainting spells and dizziness	
		Kidney disease	
		Seizures or epilepsy	Last seizure date: _____
		Abdominal/stomach/digestive problems	
		Thyroid disease	
		Skin issues	
		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	



Part B2: General Information/Health History

Full name: _____

Date of birth: _____

THIS QUESTION MUST BE ANSWERED

High-adventure base participants:

Expedition/crew No.: _____
or staff position: _____

THIS QUESTION MUST BE ANSWERED

Allergies/Medications

DO YOU USE AN EPINEPHRINE AUTOINJECTOR? Exp. date (if yes) _____ YES NO

DO YOU USE AN ASTHMA RESCUE INHALER? Exp. date (if yes) _____ YES NO

THIS QUESTION MUST BE ANSWERED

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 list on a separate sheet and attach.

Medication	Dose	Frequency	Reason

THIS QUESTION MUST BE ANSWERED

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

Administration of the above medications is approved for youth by:

Parent/guardian signature _____
THE FORM MUST BE SIGNED BY A PARENT

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. 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: _____

TETANUS DATE IS VERY IMPORTANT. WITHOUT THIS DATE, THE FORM WILL NOT BE ACCEPTED.

Part C: Pre-Participation Physical

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

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You are being asked to certify that this individual has no contraindication for participation in 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. You can also visit www.scouting.org/health-and-safety/ahmr to view this information online.

Please fill in the following information:

	Yes	No	Explain
Medical restrictions to participate			

Yes	No	Allergies or Reactions	Explain
		Medication	
		Food	

Yes	No	Allergies or Reactions	Explain
		Plants	
		Insect bites/stings	

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

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

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.
		Has no uncontrolled heart disease, lung disease, 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 planning to scuba dive, does not have diabetes, asthma, or seizures.

Examiner's signature: _____ Date: _____

Examiner's 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						
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



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