Part A: Informed Consent, Release Agreement, and Authorization

A

Full name: _____

Date of birth: _____

High-adventure base participants:

Expedition/crew No.: _____

or staff position: _____

Informed Consent, Release Agreement, and Authorization

I understand that participation in Scouting activities involves the risk of personal injury, including death, due to the physical, mental, and emotional challenges in the activities offered. Information about those activities may be obtained from the venue, activity coordinators, or your local council. I also understand that participation in these activities is entirely voluntary and requires participants to follow instructions and abide by all applicable rules and the standards of conduct.

In case of an emergency involving me or my child, I understand that efforts will be made to contact the individual listed as the emergency contact person by the medical provider and/or adult leader. 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 protected health information to the adult in charge, camp medical staff, camp management, and/or any physician or health-care provider involved in providing medical care to the participant. Protected Health Information/Confidential Health Information (PHI/CHI) under the Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. §§160.103, 164.501, etc. seq., as amended from time to time, includes examination findings, test results, and treatment provided 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.

(If applicable) I have carefully considered the risk involved and hereby give my informed consent for my child to participate in all activities offered in the program. I further authorize the sharing of the information on this form with any BSA volunteers or professionals who need to know of medical conditions that may require special consideration in conducting Scouting activities.

With appreciation of the dangers and risks associated with programs and activities, on my own behalf and/or on behalf of my child, I hereby fully and completely release and waive any and all claims for personal injury, death, or loss that may arise against the Boy Scouts of America, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with any program or activity.

I also hereby assign and grant to the local council and the Boy Scouts of America, as well as their authorized representatives, the right and permission to use and publish the photographs/film/videotapes/electronic representations and/or sound recordings made of me or my child at all Scouting activities, and I hereby 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 liability from such use and publication. I further 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 BSA, and I specifically waive any right to any compensation I may have for any of the foregoing.

Every person who furnishes any BB device to any minor, without the express or implied permission of the parent or legal guardian of the minor, is guilty of a misdemeanor. (California Penal Code Section 19915[a]) My signature below on this form indicates my permission.

I give permission for my child to use a BB device. (Note: Not all events will include BB devices.)

☐ **Checking this box indicates you DO NOT want your child to use a BB device.**

NOTE: Due to the nature of programs and activities, the Boy Scouts of America and local councils cannot continually monitor compliance of program participants or any limitations imposed upon them by parents or medical providers. However, so that leaders can be as familiar as possible with any limitations, list any restrictions imposed on a child participant in connection with programs or activities below.

List participant restrictions, if any: ☐ **None**

_____

I understand that, 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. If I am participating at Philmont Scout Ranch, Philmont Training Center, Northern Tier, Sea Base, or the Summit Bechtel Reserve, **I have also read and understand the supplemental risk advisories, including height and weight requirements and restrictions, and understand that the participant will not be allowed to participate in applicable high-adventure programs if those requirements are not met.** The participant has permission to engage in all high-adventure activities described, except as specifically noted by me or the health-care provider. If the participant is under the age of 18, a parent or guardian's signature is required.

Participant's signature: _____ Date: _____

Parent/guardian signature for youth: _____ Date: _____

(If participant is under the age of 18)

Complete this section for youth participants only:

Adults Authorized to Take Youth to and From Events:

You must designate at least one adult. Please include a phone number.

Name: _____ Name: _____

Phone: _____ Phone: _____

Adults NOT Authorized to Take Youth to and From Events:

Name: _____ Name: _____

Phone: _____ Phone: _____

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Part B1: General Information/Health History

B1

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 ☐ No ☐**
		Hypertension (high blood pressure)	
		Adult or congenital heart disease/heart attack/chest pain (angina)/ 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 ☐ No ☐**
		List all surgeries and hospitalizations	**Last surgery date:**
		List any other medical conditions not covered above	

Part B2: General Information/Health History

B2

Full name: _____

Date of birth: _____

High-adventure base participants:
Expedition/crew No.: _____
or staff position: _____

Allergies/Medications

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

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

Are you allergic to or do you have any adverse reaction to any of the following?

Yes	No	Allergies or Reactions	Explain
		Medication	
		Food	

Yes	No	Allergies or Reactions	Explain
		Plants	
		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

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

Administration of the above medications is approved for youth by:

_____ / _____

Parent/guardian signature — 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: _____

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Part C: Pre-Participation Physical

C

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

Full name: _____

Date of birth: _____

High-adventure base participants:

Expedition/crew No.: _____

or staff position: _____

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	Height (inches)	Max. Weight	Height (inches)	Max. Weight	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

DCS - Camp Chief Little Turtle Medications Administration Record
Prescription or Over-the-Counter Medications & Medical Assisted Devices

MEDICINE: <u>All medications must be in their ORIGINAL container</u>. Medications not provided in their ORIGINAL container WILL NOT be accepted. Scouts on medications must have a completed medication record sheet signed by their parent upon arrival to camp. **<u>PLEASE ONLY bring the amount needed for your stay at CCLT</u>**. Those with epi-pens, inhalers, etc. should bring ***TWO,*** marked with the Scout's full name. An extra shall be kept in the Health Lodge as a precaution.

All medications will be kept in the Medication Lockbox at the unit's campsite and will be the responsibility of each unit's leader. Only those medications that require refrigeration or other temperature controlled storage will be kept in the Health Office.

Please complete and return this form w/ your health form to your unit leader.

Name: _____ Unit #: _____ Age: _____

Dietary or Medical Concerns: _____

Parent Signature(if needed) _____ Date _____

Over-the-Counter Medication*:** I authorize the medical staff of Camp Chief Little Turtle to administer the following over-the-counter medications. ***Please circle your choices.

▶ Anti-histamines ▶ Acetaminophen ▶ Ibuprofen ▶ Cough Drops ▶ Anti-itch cream

▶ Pepto-Bismol tablets ▶ NONE ▶ OTHER: _____

***Prescription Medication*:** Medication: _____ # in bottle _____ Dose: _____

Days to be given: _____ Method: ▶ Oral ▶ Injected ▶ rectal ▶ Topical ▶ Inhaled

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
8:00 am							
12:30 pm							
6:30 pm							
9:00 pm							

***Prescription Medication*:** Medication: _____ # in bottle _____ Dose: _____

Days to be given: _____ Method: ▶ Oral ▶ Injected ▶ Rectal ▶ Topical ▶ Inhaled

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
8:00 am							
12:30 pm							
6:30 pm							
9:00 pm							

***Prescription Medication*:** Medication: _____ # in bottle _____ Dose: _____

Days to be given: _____ Method: ▶ Oral ▶ Injected ▶ rectal ▶ Topical ▶ Inhaled

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8:00 am							
12:30 pm							
6:30 pm							
9:00 pm							

***Prescription Medication*:** Medication: _____ # in bottle _____ Dose: _____

Days to be given: _____ Method: ▶ Oral ▶ Injected ▶ Rectal ▶ Topical ▶ Inhaled

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
8:00 am							
12:30 pm							
6:30 pm							
9:00 pm							

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6:30 pm							
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***Prescription Medication*:** Medication: _____ # in bottle _____ Dose: _____
Days to be given: _____ Method: ▶ Oral ▶ Injected ▶ Rectal ▶ Topical ▶ Inhaled

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
8:00 am							
12:30 pm							
6:30 pm							
9:00 pm							

*The above grids to be completed by unit leader or staff only!

Medical Assisted Device:

All Scouts/Scouters needing electricity for medical assisted devices need to notify Council Office with your units final payment. **Availability is limited.** No electricity is available in the campsites.

Please list the type of equipment you will be bringing: _____

Will electricity be needed for the device(s)? YES NO Will you be bringing a personal battery for powering your equipment? YES NO

Battery charging is available in the Administration Office for these needs.

BOY SCOUTS OF AMERICA®
ANTHONY WAYNE AREA COUNCIL

CAMP CHIEF LITTLE TURTLE SPECIAL DIETARY CONSIDERATION/RESTRICTIONS

Camp Chief Little Turtle tries to accommodate special dietary needs of Scouts and Scouters. Certain specialized needs will require parental or leadership support to ensure that dietary needs can be adequately met.

Scout/Scouter Name _____ **Date of Birth** _____ **Session** _____

Any food allergies (including milk protein allergy)? ☐ Yes ☐ No. If yes, please explain, list each allergy, including type/severity of reaction:

_____
_____

Is cross-contamination with small amounts of potentially allergy-producing food items a concern? ☐ Yes ☐ No

Is an Epi-pen required for any of these food allergies? ☐ Yes ☐ No. If yes, which ones?

_____
_____

Aside from food allergies, are there any other dietary restrictions? If yes, please list:

_____
_____

Does Scout or Scouter have a specific medically-prescribed diet? If yes, please list:

_____
_____

Does Scout or Scouter have any physical disabilities and/or conditions that make eating and/or drinking difficult? If yes, please explain below, including accommodations that need to be made while your child is at camp:

_____
_____

Are there any other special considerations or insights we should know about the Scout's or Scouter's dietary restrictions/concerns? If so, please explain:

_____
_____

11/10/14ns

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www.awac.org

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