Part A Full name: ______ DOB: ______ Allergies: ______ Emergency contact No.: ______

Annual Health and Medical Record

Part A

GENERAL INFORMATION

Name / Nombre ______ Date of birth / Fecha de nacimiento (MM/DD/Year) - (MM/DD/Año) ______ Age / Edad ______ ○ Male / Masculino ○ Female / Femenino

Address / Domicilio ______ Grade completed (youth only) / Grado escolar completado (sólo niños) ______

City / Ciudad ______ State / Estado ______ Zip / Código postal ______ Phone No. / No. telefónico ______

Unit leader / Líder de la unidad ______ Council name/No. / Nombre y no. del concilio ______ Unit No. / No. de unidad ______

Social Security No. (optional; may be required by medical facilities for treatment) / No. de Seguro Social (opcional; puede ser solicitado por las instalaciones médicas para brindar tratamiento) ______ Religious preference / Preferencia religiosa ______

Health/accident insurance company / Compañía de seguro médico/accidental ______ Policy No. / No. de póliza ______

ATTACH A PHOTOCOPY OF BOTH SIDES OF INSURANCE CARD. IF YOU DO NOT HAVE MEDICAL INSURANCE, ENTER "NONE" ABOVE.

In case of emergency, notify/

Name / Nombre ______ Relationship / Parentesco ______

Address / Domicilio ______

Home phone / Teléfono de casa ______ Business phone / Teléfono de oficina ______ Mobile phone / Teléfono móvil ______

Alternate contact name / Nombre de contacto alterno ______ Alternate's phone / Teléfono del contacto alterno ______

HEALTH HISTORY/HISTORIAL MÉDICO

Do you currently have, or have you ever been treated for any of the following?
¿Tiene actualmente, o ha tenido alguna vez los siguientes?

Please fill in the bubbles as indicated below:
Por favor rellene los círculos tal como se indica a continuación:
Incorrect: / Incorrecto ✔ ⊗ ◒ Correct: / Correcto ●

Yes/Sí	No/No	Condition/Padecimiento	Explain/Explique
○	○	**Asthma** / Asma — **Last attack:** (MM/YY) / Último ataque: (MM/AA) ☐☐/☐☐	
○	○	**Diabetes** / Diabetes — **Last HbA1c:** (Percentage) / Última HbA1c: (Porcentaje) ☐☐.☐ %	
○	○	**Hypertension (high blood pressure)** / Hipertensión (presión alta)	
○	○	**Heart disease/heart attack/chest pain/heart murmur** / Enfermedad del corazón/infarto/dolores de pecho/soplo cardíaco	
○	○	**Stroke/TIA** / Apoplejía/Accidente isquémico transitorio	
○	○	**Lung/respiratory disease** / Enfermedades pulmonares/respiratorias	
○	○	**Ear/sinus problems** / Problemas del oído/senos paranasales	
○	○	**Muscular/skeletal condition** / Condiciones musculares/óseas	
○	○	**Menstrual problems (women only)** / Problemas menstruales (sólo mujeres)	
○	○	**Psychiatric/psychological and emotional difficulties** / Dificultades psiquiátricas/psicológicas y emocionales	
○	○	**Behavioral/neurological disorders** / Trastornos de conducta/neurológicos	
○	○	**Bleeding disorders** / Enfermedades hemorrágicas	
○	○	**Fainting spells** / Desmayos	
○	○	**Thyroid disease** / Enfermedades de la tiroides	
○	○	**Kidney disease** / Enfermedades del riñón	
○	○	**Sickle cell disease** / Anemia falciforme	
○	○	**Seizures** / Convulsiones — **Last seizure:** (MM/YY) / Última convulsión: (MM/AA) ☐☐/☐☐	
○	○	**Sleep disorders (e.g., sleep apnea)** / Trastornos del sueño (por ejemplo, síndrome de apnea-hipopnea durante el sueño)	Use CPAP: / Usa CPAP ○ Yes / Sí ○ No / No
○	○	**Abdominal/digestive problems** / Problemas abdominales/digestivos	
○	○	**Surgery** / Cirugía — **Last surgery:** (MM/YY) / Última cirugía: (MM/AA) ☐☐/☐☐	
○	○	**Serious injury** / Lesión grave	
○	○	**Excessive fatigue or shortness of breath with exercise** / Fatiga en exceso o dificultad para respirar al hacer ejercicio	
○	○	**Other** / Otro	

PART A (*continued on next page*)

Part A Full name: ____________ DOB: ____________

HEALTH HISTORY/HISTORIAL MÉDICO

Are you allergic to or do you have any adverse reaction to any of the following?
¿Es alérgico a, o le causa alguna reacción adversa cualquiera de los siguientes?

Please fill in the bubbles as indicated: Incorrect: ✓ ⊗ ◒ Correct: ●
Por favor rellene los círculos tal como se indica: Incorrecto Correcto

Yes/Sí	No/No	Allergies or Reaction to Alergias o Reacciones a	Explain Explique
○	○	**Medication** Medicamentos	
○	○	**Food, plants, or insect bites** Alimentos, plantas o picaduras de insectos	

The following immunizations are recommended by the BSA. **Tetanus immunization is required and must have been received within the last 10 years.** For each item, indicate if you have been immunized, the date of the immunization (MM/YY), if you have had the disease, and the date (MM/YY).

Immunized? ¿Vacunado?		Immunizations Vacunas	Date (MM/YY) Fecha (MM/AA)	Had Disease? ¿La ha padecido?		Date (MM/YY) Fecha (MM/AA)
Yes/Sí	No/No			Yes/Sí	No/No	
○	○	**Tetanus** Tétano	☐☐ / ☐☐	○	○	
○	○	**Pertussis** Tos ferina		○	○	
○	○	**Diphtheria** Difteria		○	○	
○	○	**Measles** Sarampión		○	○	
○	○	**Mumps** Paperas		○	○	
○	○	**Rubella** Rubéola		○	○	
○	○	**Polio** Polio		○	○	
○	○	**Chicken pox** Varicela		○	○	
○	○	**Hepatitis A** Hepatitis A		○	○	
○	○	**Hepatitis B** Hepatitis B		○	○	
○	○	**Meningitis** Meningitis		○	○	
○	○	**Influenza** Influenza		○	○	
○	○	**Other (i.e., HIB)** Otra (por ejemplo, HIB)		○	○	
○	**Exemption to immunizations claimed (form required).** Exención de vacunas solicitada (formulario obligatorio).					

MEDICATIONS List all medications currently used. (If additional space is needed, please photocopy this part of the health form.) Inhalers and EpiPen information must be included, even if they are for occasional or emergency use only.

○ No medications
Sin medicamentos

○ Additional medications (sheet attached)
Medicamentos adicionales (hoja anexa)

Medication Medicamento ________ Strength / Dosis ________ Frequency / Frecuencia ________ Approximate date started Fecha aproximada de inicio ________ Reason for medication Razón del medicamento ________	Medication Medicamento ________ Strength / Dosis ________ Frequency / Frecuencia ________ Approximate date started Fecha aproximada de inicio ________ Reason for medication Razón del medicamento ________	Medication Medicamento ________ Strength / Dosis ________ Frequency / Frecuencia ________ Approximate date started Fecha aproximada de inicio ________ Reason for medication Razón del medicamento ________
Medication Medicamento ________ Strength / Dosis ________ Frequency / Frecuencia ________ Approximate date started Fecha aproximada de inicio ________ Reason for medication Razón del medicamento ________	Medication Medicamento ________ Strength / Dosis ________ Frequency / Frecuencia ________ Approximate date started Fecha aproximada de inicio ________ Reason for medication Razón del medicamento ________	Medication Medicamento ________ Strength / Dosis ________ Frequency / Frecuencia ________ Approximate date started Fecha aproximada de inicio ________ Reason for medication Razón del medicamento ________

Administration of the above medications is approved by (if required by your state): ______________________ / ______________________
La administración de los medicamentos arriba mencionados está aprobada por (si lo requiere su estado)

Parent/guardian signature / Firma del padre o tutor — and/or / y/o — MD/DO, NP, or PA signature / Firma del Dr., Enfermera profesional, Asistente médico

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.

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Part B

INFORMED CONSENT AND RELEASE AGREEMENT

I understand that participation in Scouting activities involves a certain degree of risk and can be physically, mentally, and emotionally demanding. I also understand that participation in these activities is entirely voluntary and requires participants to abide by applicable rules and standards of conduct.

In case of an emergency involving me or my child, I understand that every effort will be made to contact the individual listed as the emergency contact person. 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.

I have carefully considered the risk involved and give consent for myself and/or my child to participate in these activities. I approve the sharing of the information on this form with BSA volunteers and professionals who need to know of medical situations that might require special consideration for the safe conducting of Scouting activities.

I 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 claims or liability arising out of this participation.

◯ Without restrictions

◯ With special considerations or restrictions (list)

___

___

PART B (*continued on next page*)

Part B Full name: ______ DOB: ______

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, Philmont Training Center, Northern Tier, Florida Sea Base, or the Summit Bechtel Reserve: I have also read and understand the risk advisories explained in Part D, *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 name/ ______

Participant's signature ______ Date/Fecha ______

Parent/guardian's signature/ ______ Date/Fecha ______
(if participant is under the age of 18/si el participante es menor de 18 años)

Second parent/guardian signature/ ______ Date/Fecha ______
(if required; for example, CA/si se requiere; por ejemplo en CA)

This Annual Health and Medical Record is valid for 12 calendar months.
Este Registro Médico y de Salud Anual tiene vigencia por 12 meses calendario.

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Part C
Pre-participation Physical

TO THE EXAMINING HEALTH CARE PROVIDER

(Certified and licensed physicians [MD, DO], nurse practitioners, and physician assistants)

You are being asked to certify that this individual has no contraindication for participation in a Scouting experience as described in Part D. For individuals who will be attending a high-adventure program, either unit-based or at one of the national high-adventure bases, please refer to Part D for additional information.

Height (inches) / Estatura (pulgadas) ____ . __

Weight (pounds) / Peso (libras) ____ . __

Maximum weight for height / Máximo peso para la estatura ____

Meets height/weight limits / Cumple con los límites de estatura/peso ○ Yes/Sí ○ No/No

Blood pressure / Presión arterial ____ / ____

Pulse / Pulso ____

Percent body fat (optional) / Porcentaje de grasa corporal (opcional) ____ . __

If you exceed the maximum weight for height as explained on the next page and your planned high-adventure activity will take you more than 30 minutes away from an emergency vehicle/accessible roadway, you **will not** be allowed to participate. At the discretion of the medical advisers of the event and/or camp, participation of an individual exceeding the maximum weight for height may be allowed if the body fat percentage measured by the health care provider is determined to be 20 percent or less for a female or 15 percent or less for a male. (Philmont requires a hydrostatic weighing or DXA test to be used for this determination.) Please call the event leader and/or camp if you have any questions. Enforcing the height/weight guidelines is strongly encouraged for all other events.

Examiner: Please fill in the information.

Please fill in the bubbles as indicated: / Por favor rellene los círculos tal como se indica: Incorrect: / Incorrecto ✔ ✖ ◒ Correct: / Correcto ●

	Normal Normal	Abnormal Anormal	Explain Any Abnormalities Explique cualquier anomalía
Eyes Ojos	○	○	
Ears Oídos	○	○	
Nose Nariz	○	○	
Throat Garganta	○	○	
Lungs Pulmones	○	○	
Neurological Neurológico	○	○	
Heart Corazón	○	○	
Abdomen Abdomen	○	○	
Genitalia/hernia Genitales/hernia	○	○	
Skin Piel	○	○	
Emotional adjustment Ajuste emocional	○	○	

Range of Mobility Rango de movilidad	Normal Normal	Abnormal Anormal	Explain Any Abnormalities Explique cualquier anomalía
Knees (both) Rodillas (ambas)	○	○	
Ankles (both) Tobillos (ambos)	○	○	
Spine Espina	○	○	

Other Otro	Yes Sí	No No	Explain Explique
Personal or family history of heart disease Historial personal o familiar de enfermedad cardíaca	○	○	
Medical equipment (i.e., CPAP, oxygen) Equipo médico (por ejemplo, CPAP, oxígeno)	○	○	
Contacts Lentes de contacto	○	○	
Dentures Dentaduras	○	○	
Braces Tratamientos de ortodoncia	○	○	

Tuberculosis (TB) skin test (if required by your state for BSA camp staff): ○ Negative/Negativo ○ Positive/Positivo
Prueba de Tuberculosis (TB) (si lo requiere su estado para personal del campamento BSA)

Allergies/Alergias: ○ No/No ○ Yes/Sí (explain to what agent, type of reaction, treatment/explique a qué agente, tipo de reacción, tratamiento):

Medical restrictions to participate/Restricciones médicas para participar: ○ No/No ○ Yes/Sí (explain/explique):

Part C Full name: ____ DOB: ____

PART C (*continued on next page*)

Part C Full name: ________ DOB: ________

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 above):

Please fill in the bubbles as indicated:
Por favor rellene los círculos tal como se indica:

Incorrect: / Incorrecto — Correct: / Correcto

True / Cierto	False / Falso	
○	○	**Meets height/weight requirements**
○	○	**Does not have uncontrolled heart disease, asthma, 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 less than 18 years of age and planning to scuba dive, does not have diabetes, asthma, or seizures**
○	○	**I have reviewed Part D for high-adventure activities.**

Provider printed name
Nombre del proveedor ________

Address
Domicilio ________

City, state, zip
Ciudad, estado, código postal ________

Office phone
Teléfono del consultorio ________

Date
Fecha ________

Examiner signature in the box below.
Firma del examinador en el recuadro de abajo.

Height (inches)	Recommended Weight (lbs)	Allowable Exception	Maximum Acceptance
60	97-138	139-166	166
61	101-143	144-172	172
62	104-148	149-178	178
63	107-152	153-183	183
64	111-157	158-189	189
65	114-162	163-195	195
66	118-167	168-201	201
67	121-172	173-207	207
68	125-178	179-214	214
69	129-185	186-220	220
70	132-188	189-226	226
71	136-194	195-233	233
72	140-199	200-239	239
73	144-205	206-246	246
74	148-210	211-252	252
75	152-216	217-260	260
76	156-222	223-267	267
77	160-228	229-274	274
78	164-234	235-281	281
79 & over	170-240	241-295	295

This table is based on the revised Dietary Guidelines for Americans from the U.S. Dept. of Agriculture and the Dept. of Health & Human Services.

Esta tabla está basada en los Lineamientos dietéticos para estadounidenses del Departamento de Agricultura de los EE.UU. y del Departamento de Salud y Servicios Humanos.

DO NOT WRITE IN THIS BOX
NO ESCRIBA EN ESTE RECUADRO

REVIEW FOR CAMP OR SPECIAL ACTIVITY/REVISIÓN PARA CAMPAMENTO O ACTIVIDAD ESPECIAL

Reviewed by
Revisado por ________

Date
Fecha ________

Further approval required / Se requiere aprobación adicional ○ Yes / Sí ○ No / No

Reason
Razón ________

Approved by
Aprobado por ________

Date
Fecha ________

Click here for more information regarding high-adventure outings or go to www.scouting.org/filestore/HealthSafety/pdf/part_d.pdf.
Haga clic aquí para obtener más información sobre las excursiones de aventura extrema o visite www.scouting.org/filestore/HealthSafety/pdf/part_d.pdf.

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