PARTICIPANT HEALTH HISTORY FORM

Please fill out the following information & attach the requested additional information to be turned in at registration of camp.

Dates will attend camp: from _____to_____
Month/Day/Year Month/Day/Year

Camper Name: _____
First Middle Last

□ Male □ Female Birth Date _____ Age on arrival at camp: _____

CONTACT INFORMATION

Camper Home Address: _____
Street Address City State Zip Code

Parent/guardian with legal custody to be contacted in case of illness or injury:
Name: _____ Relationship to Camper: _____
Preferred Phone #: (_____) _____
Email: _____
Home Address: _____
(If different from above) Street Address City State Zip Code

Second parent/guardian or other emergency contact:
Name: _____ Relationship to Camper: _____
Preferred Phone #: (_____) _____
Email: _____

Additional contact in event parent(s)/guardian(s) cannot be reached:
Name: _____Relationship to Camper: _____
Preferred Phone #: (_____) _____

INFORMED CONSENT & TALENT RELEASE

I understand that participation in camp 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 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 volunteers or professionals who need to know of medical conditions that may require special consideration in conducting camp 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.

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. The participant has permission to engage in all 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: _____

MEDICAL INFORMATION

Allergies:
Are you allergic to or do you have any adverse reactions to the following?

Yes	No	Allergies/Reactions	Explain
☐	☐	Medication	
☐	☐	Food	
☐	☐	Plants	
☐	☐	Insect bites/Stings	

Medication: ☐ This camper will not take any daily medications while attending camp.
☐ This camper will take the following daily medication(s) while at camp:

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. ***Please review camp instructions about required packaging/containers. Many states require original pharmacy containers with labels which show the camper's name and how the medication should be given. Provide enough of each medication to last the entire time the camper will be at camp.***

Name of Medication	Reason for Taking	When it is given	Amount/Dose	How is it given?
		• Breakfast • Lunch • Dinner • Other: _____		
		• Breakfast • Lunch • Dinner Other: _____		
		• Breakfast • Lunch • Dinner Other: _____		

(If additional lines are necessary, please attach on a separate sheet.)

The following non-prescription medications may be stocked in the camp Health Office and are used on an as needed basis to manage illness and injury. ***Cross out those the camper should not be given.***

- Acetaminophen (Tylenol)
- Phenylephrine decongestant (Sudafed PE)
- Antihistamine/allergy medicine
- Diphenhydramine antihistamine/allergy medicine (Benadryl)
- Sore throat spray
- Lice shampoo or cream (Nix or Elimite)
- Calamine lotion
- Laxatives for constipation (Ex-Lax)
- Ibuprofen (Advil, Motrin)
- Pseudoephedrine decongestant (Sudafed)
- Guaifenesin cough syrup (Robitussin)
- Dextromethorphan cough syrup (Robitussin DM)
- Generic cough drops
- Antibiotic cream
- Aloe
- Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol)

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.

Non-prescription medication administration is approved for youth by

Parent/Guardian: _____ Date: _____

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 (Date)	Immunization	Date(s)
☐	☐		COVID-19	
☐	☐		Tetanus	
☐	☐		Pertussis	
☐	☐		Diphtheria	
☐	☐		Measles/Mumps/Rubella	
☐	☐		Polio	
☐	☐		Chicken Pox	
☐	☐		Hepatitis A	
☐	☐		Hepatitis B	
☐	☐		Meningitis	
☐	☐		Influenza	
☐	☐		Other (i.e. HIB)	

Please list any additional information about your camper's medical history that may aid us in providing care:

_____

_____

_____

_____

_____

Medical Insurance Information:

This camper is covered by family medical/hospital insurance ☐ Yes ☐ No

Insurance Company_____ Policy Number_____

Subscriber_____ Insurance Company Phone Number (_____) _____

Include a copy of your insurance card, if appropriate; copy both sides of the card so information is readable.

Parent/Guardian Authorization for Health Care:
The aforementioned health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities, except as noted by myself, and/or an examining physician. I give permission to the medical professional selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the medical professional to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand that the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child, and these providers may talk with the program's staff about my child's health status.

Parent/Guardian _____ Date: _____ Relationship to Camper: _____

FOR CAMP USE ONLY:
REVIEWED BY: _____ DATE: _____
APPORVED BY: _____ DATE: _____