

Camp Workcoeman Short Term Medical Form

Name _____ Date of Birth _____
 Age _____ Gender _____ Height (in) _____ Weight (lbs.) _____
 Address _____ City _____ State _____ Zip _____
 Council _____ Unit No. _____
 Unit Leader _____ Unit Leaders Mobil # _____
 Health Insurance Company _____ Policy Number _____
 Parents name _____ Phone Number _____
 Emergency Contact _____ Phone Number _____
 Do you have any allergies to: Medications explain) _____
 Food (explain) _____ Plants (explain) _____
 Insect bites/stings (explain) _____

Do you use epinephrine injector or an inhaler? Yes or No If yes, under 18 years old & not accompanied by a parent/guardian, attach EMERGENCY TREATMENT PLAN FOR ALLERGIC REACTIONS FORM.

MEDICATION	DOSE	FREQUENCY	REASON

Are any medications to be administered by Camp Staff? YES NO If yes attach an AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION FOR EACH MEDICATION

HEALTH HISTORY (check all that apply)

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Neurological/behavioral disorders
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Blood Disorders
<input type="checkbox"/> Any heart related disease	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Surgeries	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Stroke/TIA	<input type="checkbox"/> Seizures/epilepsy
<input type="checkbox"/> Asthma	<input type="checkbox"/> Digestive issues
<input type="checkbox"/> Lung/Respiratory disease; COPD	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Ear/eyes/nose/sinus problems	<input type="checkbox"/> Skin issues
<input type="checkbox"/> Muscular/skeletal issues	<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Head injury/concussion/TBI	<input type="checkbox"/> Other (specify)

IMMNUIZATION & YEAR

<input type="checkbox"/> TETANUS	<input type="checkbox"/> POLIO	<input type="checkbox"/> MENINGITIS	<input type="checkbox"/> OTHER:
<input type="checkbox"/> PERTUSSIS	<input type="checkbox"/> CHICKEN POX	<input type="checkbox"/> INFLUENZA	
<input type="checkbox"/> DIPHTHERIA	<input type="checkbox"/> HEPATITIS A	<input type="checkbox"/> HIB	
<input type="checkbox"/> MEASLES/MUMPS/RUBELLA	<input type="checkbox"/> HEPATITIS B	<input type="checkbox"/> COVID	<input type="checkbox"/> EXEMPT (ATTACH FORM)

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.

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.

Required: Click on the following link and read Form D – Connecticut Rivers Council Addendum.
[health-form.pdf \(campworkcoeman.org\)](http://health-form.pdf(campworkcoeman.org))

I have read Form D. Initials _____

Any restrictions or Comments:

Signature _____ Date _____
(Adults over 18, sign here. Parent/Guardian signs for camper)

Name (print) _____ Relationship _____