

Part A: Informed Consent, Release Agreement, and Authorization

Full name: _____

DOB: _____

Informed Consent, Release Agreement, and Authorization

I understand that participation in Learning for Life activities involves a certain degree of risk. I have carefully considered the risk involved and have given consent for myself and/or my child to participate in these activities. I understand that participation in these activities is entirely voluntary and requires participants to abide by applicable rules and standards of conduct. I release Learning for Life, 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.

I approve the sharing of the information on this form with Learning for Life volunteers and professionals who need to know of medical situations that might require special consideration for the safe conducting of Learning for Life activities.

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 to the adult in charge 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

ADULTS AUTHORIZED TO TAKE YOUTH TO AND FROM EVENTS

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

1. Name _____ Telephone _____

2. Name _____ Telephone _____

3. Name _____ Telephone _____

Adults NOT authorized to take youth to and from events:

1. Name _____

2. Name _____

3. Name _____

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.

Participant's name: _____ Date: _____

Participant's signature: _____ Date: _____

Parent/guardian signature for youth: _____ Date: _____

(If participant is under the age of 18)

Second parent/guardian signature for youth: _____ Date: _____

(If required; for example, CA)

This Annual Health and Medical Record is valid for 12 calendar months.

Part B: General Information/Health History

Full name: _____

DOB: _____

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

Address: _____

City: _____ State: _____ ZIP code: _____ Telephone: _____

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:
		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	Last attack date:
		Lung/respiratory disease	
		COPD	
		Ear/eyes/nose/sinus problems	
		Muscular/skeletal condition/muscle or bone issues	
		Head injury/concussion	
		Altitude sickness	
		Psychiatric/psychological or emotional difficulties	
		Behavioral/neurological disorders	
		Blood disorders/sickle cell disease	
		Fainting spells and dizziness	
		Kidney disease	
		Seizures	Last seizure date:
		Abdominal/stomach/digestive problems	
		Thyroid disease	
		Excessive fatigue	
		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 B: General Information/Health History

Full name: _____

DOB: _____

Allergies/Medications

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 INDICATE 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. **!**

**CHALLENGE COURSE and CLIMBING/RAPPELLING HEALTH HISTORY AND CONSENT FORM
ADULT OR CHILD**

You are about to take part in a challenge (“ropes”) course experience and or climbing/rappelling (“activity”) offered through the__Council BSA (“local council”) on_____(date).

While participating in the activity you will undertake a wide variety of physical and mental challenges that are comparable to activities with which you may be more familiar. Much of the time, you will be engaged in activity of “moderate exertion,” which is comparable to normal walking, golfing on foot, raking leaves, calisthenics, or slow dancing. For short periods of time, you will be engaged in activity of “vigorous exertion,” which is comparable to fast walking, slow jogging, heavy gardening, or shoveling snow.

If any of the above activities are difficult for you, discuss your participation in the activity with your physician. If these are activities in which you regularly engage without difficulty, you should be fit for participation in the program.

Following are specific medical conditions about which participants should *always* seek the advice of a physician before participating in the activity:

- Pregnancy (climbing harness can injure uterus)
- Kidney or liver transplant (climbing harness can injure transplanted organ)
- Healing fracture or joint injury (should be cleared by treating physician)
- Recent surgery (should be cleared by treating physician)
- Down syndrome (should have x-ray check for neck instability, as per recommendation of the Special Olympics)

If you or your physician has any questions about the physical requirements of the activity, feel free to contact the local council.

HEALTH HISTORY

Name:			
<small>First</small>	<small>Middle</small>	<small>Last</small>	
Telephone:			
<small>Home</small>			<small>Work</small>
Personal physician		Telephone:	
<small>Name</small>			
In case of emergency, please contact:		Telephone:	
<small>Name</small>			
Special dietary considerations:			
List known allergies:			
List required medications:			
If you are allergic to insect stings, do you have an insect sting kit (e.g., EpiPen)?			
Do you wear contact lenses?	<input type="radio"/> Yes	<input type="radio"/> No	Are you pregnant?
			<input type="radio"/> Yes <input type="radio"/> No
Have you had or do you now have (check if yes):		Heart attack	Diabetes
Angina	Epilepsy	Chest pains	Asthma
	Drug reactions	High blood pressure	Heart murmur
If you answered “yes” to any of the above, explain and include date:			
Do you have any other medical conditions that we should be aware of?			

HOLD HARMLESS AGREEMENT

I understand that participation in the activity involves a certain degree of risk that could result in injury or death. In consideration of the benefits to be derived, after carefully considering the risk involved, and in view of the fact that the Boy Scouts of America is an organization in which membership is voluntary, I have carefully considered the risk involved and have given consent for myself (or my son or daughter) to participate in the activity, and waive all claims I or we may have against the Boy Scouts of America, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with the activity.

I am not under the influence of any chemical substance, including alcohol. Understanding that any physical activity involves a risk of injury, I understand that my participation in the activity is entirely voluntary. 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. This release does not, however, apply to any harm caused by negligence or willful misconduct of the local council or its employees.

In case of emergency involving my child, I understand every effort will be made to contact me. In the event I cannot be reached, I hereby give my permission to the physician selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child.

Participant’s signature* _____ Date _____

*If the participant is under age 18, his or her parent or guardian must also sign below:

Parent’s or guardian’s signature _____ Date _____