

**ADULT HEALTH & MEDICAL RECORD---Leader – BS/CS Staff – BS/CS**

Please sign all areas with this mark \*\*  
(For use by all individuals 18 years and older)

Note:  
The Boy Scouts of America requires that adults (under 40) participating in any long-term camping experience (more than 72 hours):

- a. MUST have a medical evaluation by a licensed medical provider within **36 months** of the camping experience.
- b. MUST have a health history completed within **12 months** of the camping experience.
- c. Adults 40 and over – must have medical evaluation and health history completed every **12 months**.

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Unit # \_\_\_\_\_  
Last Name First Name Initial  
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

**IN CASE OF EMERGENCY, NOTIFY:**

Name: \_\_\_\_\_ AM Phone ( ) \_\_\_\_\_  
Street Address \_\_\_\_\_ PM Phone ( ) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Pager \_\_\_\_\_

**IF PERSON NAMED ABOVE IS NOT AVAILABLE IN THE EVENT OF AN EMERGENCY, NOTIFY:**

Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_ Relationship \_\_\_\_\_  
Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_ Relationship \_\_\_\_\_

Medical Provider \_\_\_\_\_ Provider Phone ( ) \_\_\_\_\_

Family Health / Accident Insurance \_\_\_\_\_ Policy No. \_\_\_\_\_

In the event that I am injured and rendered unconscious, I hereby give permission to the medical provider selected by a designated representative of the Boy Scouts of America to authorize medical surgical treatment, routine, non-surgical medical care, hospitalization, proper anesthesia and/or medication(s) / injection(s). I assume health and financial responsibility for myself.

\*\* \_\_\_\_\_  
Signature Date

**CONSENT TO RELEASE INFORMATION**

**Do you give your consent for the La Salle Council of the BSA to request the State Police to conduct a confidential criminal history file search of your records as a prerequisite for serving as a youth leader in Scouting?**

\_\_\_\_\_ Yes \_\_\_\_\_ No \*\* \_\_\_\_\_  
Your signature is required for consent Date

\_\_\_\_\_  
Current Drivers License Number State of Issue

**ADULT HEALTH HISTORY  
(To Be Completed by Adult)**

**IF YES IS CHECKED, PLEASE GIVE FULL DETAILS**

\* **HAVE OR SUBJECT TO:** (Check if YES)

**IF NONE:** Check here \_\_\_\_\_

_____ Heart Problems	_____ Asthma*****Uses an Inhaler	No _____	Yes _____
_____ Seizure/convulsion Disorder	_____ Diabetes*****Uses Insulin	No _____	Yes _____
_____ Kidney Disorder	_____ Behavioral/Emotional Concerns	_____	
_____ Medication Allergies:	List _____	_____	
_____ Food Allergies:	List _____	_____	
_____ Seasonal Allergies:	List _____	_____	
_____ Stinging Insect Reaction:	Treatment _____	_____	
_____ Fainting Spells	_____		
_____ Bleeding Disorder	_____		
_____ Other Health Concern(s):	_____		

\***HAVE DIFFICULTY WITH:** (Check if YES)

**IF NONE:** Check here \_\_\_\_\_

_____ Tires easily	_____ Muscle Fatigue	_____ Ear Infections
_____ Breathing	_____ Nose Bleeding	_____ Sinus Infections
_____ Stomach/Bowels	_____ Sleeping	_____ Athletes Foot

Explain: \_\_\_\_\_

\***CURRENT HEALTH STATUS:** (Check if YES)

**IF NONE:** Check here \_\_\_\_\_

_____ Currently under medical care.	{ Explain: _____
_____ Currently taking any medications.	{ Complete CURRENT MEDICATION SECTION
_____ Serious illness/injury in past year	Explain: _____
_____ Current behavioral/emotional concerns.	Explain: _____
_____ Other current health concerns.	Explain: _____
_____	
_____ Diet restrictions.	Explain: _____
_____ Activity restrictions.	Explain: _____
_____ Wears contacts.	_____ Wears bridge work or dentures

**\*IMMUNIZATION HISTORY**

(MUST indicate last inoculation date(s):

_____ Tetanus Booster	_____ Negative TB Test of Chest X-Ray (STAFF ONLY)
_____ Hepatitis B (optional)	_____ Haemophilus influenza B (optional)

**The following immunizations are current and up to date:**

- MMR (measles, mumps, rubella)
- DPT (diphtheria, pertussis, tetanus)
- Polio, Smallpox, Varicella (Chicken Pox), BCG
- And other \_\_\_\_\_

**Special Diet needs or restrictions:** \_\_\_\_\_  
\_\_\_\_\_

\*\* Signature \_\_\_\_\_ Date \_\_\_\_\_

\*\* Signature \_\_\_\_\_ Date \_\_\_\_\_

\*\* Signature \_\_\_\_\_ Date \_\_\_\_\_

Current year signature required

**CURRENT MEDICATIONS: (Prescriptions & Non-Prescriptions)**

\_\_\_\_\_ I take NO medications on a routine basis

I take the following medications on a regular basis.

Med # 1 \_\_\_\_\_ Dosage \_\_\_\_\_ Times to be given \_\_\_\_\_

Med # 2 \_\_\_\_\_ Dosage \_\_\_\_\_ Times to be given \_\_\_\_\_

Med # 3 \_\_\_\_\_ Dosage \_\_\_\_\_ Times to be given \_\_\_\_\_

Med # 4 \_\_\_\_\_ Dosage \_\_\_\_\_ Times to be given \_\_\_\_\_

Med # 5 \_\_\_\_\_ Dosage \_\_\_\_\_ Times to be given \_\_\_\_\_

Attach additional pages for more medications.

**TO BE COMPLETED BY A LICENSED MEDICAL PROVIDER**

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I certify that I have examined \_\_\_\_\_ on \_\_\_\_\_  
Adults Name Date of Exam

And find him/her physically fit to participate in all Scouting activities EXCEPT as noted below. The aforementioned individual has all required immunizations as required by the State of Michigan.

Ht. \_\_\_\_\_ Wt. \_\_\_\_\_ B/P. \_\_\_\_\_ / \_\_\_\_\_ Pulse \_\_\_\_\_

Check box if NORMAL: Circle if ABNORMAL and give details below:

_____ GI	_____ Endocrine	_____ Genitourinary	_____ Skin, glands, hair
_____ Respiratory	_____ Skeletomuscular	_____ Head, Neck, thyroid	_____ Cardiovascular
_____ Neuropsychiatric	_____ Eyes, Ears, Nose	_____ Abdomen, Hernia	_____ Other (Specify)

Comments: \_\_\_\_\_

Restrictions/Limitations: \_\_\_\_\_

Provider Signature \_\_\_\_\_ Provider Name \_\_\_\_\_

Provider Phone Number ( ) \_\_\_\_\_

**The Michigan Department of Consumer and Industry Services pursuant to public Act 116 of 1973 and Administrative Rule 109.(4) REQUIRES the following information.**

Registered position in council: \_\_\_\_\_ Position in Camp \_\_\_\_\_  
 Number of years registered with the BSA: \_\_\_\_\_ years.  
 Number of years/seasons in summer camp as an adult leader: \_\_\_\_\_ years.  
 Number of years in Leadership of short term weekend camping: \_\_\_\_\_ years.

**Please indicate training received and date issued:**

**BSA Training**

Basic Leader Training \_\_\_\_\_  
 Youth Protection \_\_\_\_\_  
 Woodbadge \_\_\_\_\_  
 Camp School \_\_\_\_\_  
 Section \_\_\_\_\_

**Health and Safety Training**

CPR (Red Cross/American Heart) \_\_\_\_\_  
 Basic First Aid (Red Cross) \_\_\_\_\_  
 Other Medical Trng / License \_\_\_\_\_  
 Describe \_\_\_\_\_

**Water Safety Training**

Safe Swim Defense \_\_\_\_\_  
 Safety Afloat \_\_\_\_\_  
 ARC Water Safety Inst. \_\_\_\_\_  
 BSA Lifeguard \_\_\_\_\_  
 Other \_\_\_\_\_  
 Describe \_\_\_\_\_

**Field Sports Training**

National Rifle Association \_\_\_\_\_  
 National Archery Association \_\_\_\_\_  
 Hunter Safety Instructor \_\_\_\_\_

**Other Outdoor Education Skills/Hobbies**

Explain \_\_\_\_\_

Have you ever been convicted of anything other than minor traffic violations? \_\_\_\_\_ yes \_\_\_\_\_ no

If yes, please explain \_\_\_\_\_

**My signature below verifies that I have knowledge and understanding of the requirements for reporting suspected cases of child abuse/neglect, as stated in the camp policy dealing with child abuse/neglect and that the information on this form is correct to the best of my knowledge.**

**\*\* Signature \_\_\_\_\_ Date \_\_\_\_\_**

**REFERENCES FOR ADULT LEADERS (Must be completed prior to camp)**

As a representative for the above-identified individual's unit, I recommend him/her to serve as an adult leader for BSA.

\_\_\_\_\_  
 Signature of registered adult from individual's unit                      Print Name                      Unit #

Knowing the good character of the above-identified individual, I recommend him/her to serve as an adult leader for BSA

\_\_\_\_\_  
 Character Reference Signature # 1                      Print Name

Knowing the good character of the above-identified individual, I recommend him/her to serve as an adult leader for BSA

\_\_\_\_\_  
 Character Reference Signature # 2                      Print Name