

Annual BSA Health and Medical Record

Part A

GENERAL INFORMATION

Name _____ Date of birth _____ Age _____ Male Female
 Address _____ Grade completed (youth only) _____
 City _____ State _____ Zip _____ Phone No. _____
 Unit leader _____ Council name/No. _____ Unit No. _____
 Social Security No. (optional; may be required by medical facilities for treatment) _____ Religious preference _____
 Health/accident insurance company _____ Policy No. _____

ATTACH A PHOTOCOPY OF BOTH SIDES OF INSURANCE CARD (SEE PART C). IF FAMILY HAS NO MEDICAL INSURANCE, STATE "NONE."

In case of emergency, notify:

Name _____ Relationship _____
 Address _____
 Home phone _____ Business phone _____ Cell phone _____
 Alternate contact _____ Alternate's phone _____

MEDICAL HISTORY

Are you now, or have you ever been treated for any of the following:

Yes	No	Condition	Explain
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	
<input type="checkbox"/>	<input type="checkbox"/>	Hypertension (high blood pressure)	
<input type="checkbox"/>	<input type="checkbox"/>	Heart disease (i.e., CHF, CAD, MI)	
<input type="checkbox"/>	<input type="checkbox"/>	Stroke/TIA	
<input type="checkbox"/>	<input type="checkbox"/>	COPD	
<input type="checkbox"/>	<input type="checkbox"/>	Ear/sinus problems	
<input type="checkbox"/>	<input type="checkbox"/>	Muscular/skeletal condition	
<input type="checkbox"/>	<input type="checkbox"/>	Menstrual problems (women only)	
<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric/psychological and emotional difficulties	
<input type="checkbox"/>	<input type="checkbox"/>	Learning disorders (i.e., ADHD, ADD)	
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding disorders	
<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells	
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	
<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	
<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell disease	
<input type="checkbox"/>	<input type="checkbox"/>	Seizures	
<input type="checkbox"/>	<input type="checkbox"/>	Sleep disorders (i.e., sleep apnea)	
<input type="checkbox"/>	<input type="checkbox"/>	GI problems (i.e., abdominal, digestive)	
<input type="checkbox"/>	<input type="checkbox"/>	Surgery	
<input type="checkbox"/>	<input type="checkbox"/>	Serious injury	
<input type="checkbox"/>	<input type="checkbox"/>	Other	

Allergies or Reaction to:

Medication _____
 Food, Plants, or Insect Bites _____

Immunizations:

The following are recommended by the BSA. Tetanus immunization must have been received within the last 10 years. If had disease, put "D" and the year. If immunized, check the box and the year received.

Yes	No	Date
<input type="checkbox"/>	<input type="checkbox"/>	Tetanus _____
<input type="checkbox"/>	<input type="checkbox"/>	Pertussis _____
<input type="checkbox"/>	<input type="checkbox"/>	Diphtheria _____
<input type="checkbox"/>	<input type="checkbox"/>	Measles _____
<input type="checkbox"/>	<input type="checkbox"/>	Mumps _____
<input type="checkbox"/>	<input type="checkbox"/>	Rubella _____
<input type="checkbox"/>	<input type="checkbox"/>	Polio _____
<input type="checkbox"/>	<input type="checkbox"/>	Chicken pox _____
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A _____
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B _____
<input type="checkbox"/>	<input type="checkbox"/>	Influenza _____
<input type="checkbox"/>	<input type="checkbox"/>	Other (i.e., HIB) _____

Exemption to immunizations claimed.

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.

(For more information about immunizations, as well as the immunization exemption form, see Scouting Safely on Scouting.org.)

Medication _____ Strength _____ Frequency _____ Approximate date started _____ Reason for medication _____ Distribution approved by: _____ Parent signature _____ MD/DO, NP, or PA Signature Temporary <input type="checkbox"/> Permanent <input type="checkbox"/>	Medication _____ Strength _____ Frequency _____ Approximate date started _____ Reason for medication _____ Distribution approved by: _____ Parent signature _____ MD/DO, NP, or PA Signature Temporary <input type="checkbox"/> Permanent <input type="checkbox"/>	Medication _____ Strength _____ Frequency _____ Approximate date started _____ Reason for medication _____ Distribution approved by: _____ Parent signature _____ MD/DO, NP, or PA Signature Temporary <input type="checkbox"/> Permanent <input type="checkbox"/>
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NOTE: Be sure to bring medications in the appropriate containers, and make sure that they are NOT expired, including inhalers and EpiPens. You SHOULD NOT STOP taking any maintenance medication.

Emergency contact no.:

Allergies:

DOB:

Last name: