

Central New Jersey Council, Boy Scout of America
Personal Health and Medical Record / Medication Release
Class 1 and Class 2

NAME

Class 1 (must be updated annually). For day and weekend activities with levels of activity similar to that of home or school. Medical care is readily available. Current health and medical history is attested by parents.

Class 2 (required once every 3 years for participants under 40 years of age). For resident camping programs or any activity such as backpacking or recreational sports. Medical care is readily available.

If the participant has had a physical examination within the past 36 months, a copy of the results of this examination may be attached along with the completed Class 1 in place of the Class 2 examination. These medical examinations must be completed by a licensed health care practitioner.

CLASS 1 PERSONAL HEALTH AND MEDICAL HISTORY
 (To be filled out annually by all participants)

To be filled out by parent, guardian or adult participant. Please print in ink.

IDENTIFICATION

Name _____ Date of birth _____ Age _____ Sex _____

Name of parent or guardian _____ Telephone _____

Home address _____ City _____ State _____ Zip _____

If the person named above is not available in the event of an emergency, notify

Name _____ Relationship _____ Telephone _____

Name _____ Relationship _____ Telephone _____

Name of personal physician _____ Telephone _____

Personal health/accident insurance carrier _____ Policy No. _____

Check all items that apply, **past or present**, to your health history. Explain any "YES" answers

ALLERGIES: Food, medicines, insects, plants Yes ___ No ___ Explain: _____

GENERAL INFORMATION

Attention-Deficit Hyperactivity Disorder	Yes ___ No ___	High Blood Pressure	Yes ___ No ___	Cancer/ Leukemia	Yes ___ No ___
Convulsions/Seizures	Yes ___ No ___	Diabetes	Yes ___ No ___	Heart Trouble	Yes ___ No ___
Hemophilia	Yes ___ No ___	Asthma	Yes ___ No ___	Kidney Disease	Yes ___ No ___

Explain: _____

Please list ALL medications taken in the 30 days prior to arrival at the Scouting activity where this form is to be used:

List any medications to be taken at camp: _____

List any physical or behavioral conditions that may effect or limit full participation in swimming, backpacking, hiking long distances or playing strenuous physical games: _____

List equipment needed such as wheelchair, braces, glasses, etc: _____

Immunizations (Give date of last inoculation)

Tetanus toxoid _____	Measles _____	Polio _____	Diphtheria _____
Mumps _____	Pertussis _____	Rubella _____	

TROOP

CAMPSITE

By signing the reverse side of this form, I hereby consent to the use of my or my child's voice and/or photographic image in the news coverage, video taping, camp promotional materials or similar projects approved by the Central New Jersey Council, BSA.

CLASS 2 PERSONAL HEALTH AND MEDICAL HISTORY

NAME

Name _____ Age _____

NOTE TO LICENSED HEALTH-CARE PRACTITIONERS: The person being evaluated will be attending one or more weeks of camp that may include sleeping on the ground and participating in strenuous activities such as hiking, swimming and vigorous group games. **Please explain any "abnormal" evaluations.**

PHYSICAL EXAMINATION (To be filled out by a licensed health-care practitioner)

Height _____ Weight _____ BP _____ / _____ Pulse _____

VISION: Normal _____ Glasses _____ Contacts _____

HEARING: Normal _____ Abnormal _____ Explain _____

Growth Development	Nor ___ Abn ___	Teeth	Nor ___ Abn ___	Cardiopulmonary System	Nor ___ Abn ___
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Skin	Nor ___ Abn ___	Hernia	Nor ___ Abn ___	Musculoskeletal	Nor ___ Abn ___
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HEENT	Nor ___ Abn ___	Genitalia	Nor ___ Abn ___	Neurobehavioral	Nor ___ Abn ___
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Explain _____

Limitations

Activity Restrictions _____

Diet Restrictions _____

Signature _____ Date _____

Address _____ Telephone _____

City, State, Zip _____

TROOP

CNJC DRUG & MEDICATION POLICY—[CONSENT TO ADMINISTER MEDICATIONS AT SUMMER CAMP]

1. Prescription medication shall be administered only after receipt of written authorization from the child's parent, guardian, or the directing physician.
2. Prescription medication shall be stored in the original prescription container.
3. Non-prescription medication shall be administered only after receipt of written authorization from the child's parent or guardian, or in accordance with the camp's standing orders. [This includes medication such as aspirin, Tylenol, stomach remedies, etc.].
4. All Non-prescription medication shall be labeled and stored in the original container as provided by doctor or pharmacist.
5. All medications must be in a re-sealable plastic bag that bears the scout's name, and troop/pack number.
6. The medical staff shall ONLY administer medications authorized by parents, guardians, the attending physician, or the camp physician in the case of standing orders.
7. All Prescriptions and Non-Prescriptions are to be given to the camp Health Officer upon arrival at camp. Any medications that are not picked up at the end of the summer camp stay will be destroyed three days after departure from camp.
8. Are there any other medical/behavioral problems we should be aware of: () Yes () No (explain)

As a parent/legal guardian of the above named youth member who will be attending one or more of the CENTRAL NEW JERSEY COUNCIL'S CAMPS, I have read and understand the above medication policy and hereby authorize the health/medical staff of the camp to administer the identified prescription and/or "over the counter," non-prescription medications in [the scout's] personal possession on entering camp and as described in the attached Personal Health & Medical Record form.

What Over the Counter medicines can this child receive if needed? Parents must check all allowed:

- Tylenol Advil Ibuprofen Pepto Bismal Alka Seltzer Tums Robitussin (plain) Cough drops/throat lozenges Benadryl Non Aspirin Acetaminophen Sinus/ Allergy Relief Tabs Calamine Lotion _____

I give permission for full participation in BSA programs, subject to limitations noted herein. In case of emergency, I understand that every effort will be made to contact me (if participant in an adult, my spouse or next of kin). In the event I can not be reached, I hereby give my permission to the licensed health-care practitioner selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery or injections of medication for my child (or for me, if participant is an adult).

I can be reached at the following numbers during the week:

Home: _____ Cell: _____

Work: _____ Other: _____

Signature of parent/ legal guardian _____ Printed name of parent/legal guardian _____ Date: ____/____/____
2/2006

CAMP SITE