Annual	<b>BSA</b>	Health	and	Medical	Record
Donat A					

GENE	RAL IN	IFORMATION						
Name			Date of birth		Ag	ge	_ Male 🗆	Female □
Address					Gr	rade complete	d (youth on	ıly)
					Phone No			
						Unit No		
			lical facilities for treatment)					
		ATTACH A PHOTO IF FAMIL	COPY OF BOTH SIDES OF INSULY HAS NO MEDICAL INSURANC	JRANCE CARD	(SEE F			
		nergency, notify:	Dele					
			Rela	itionship				
Home p	phone _		Business phone	Cell	phone			
Alterna	ite conta	ıct	A	Alternate's phone				
MEDI	CAL HI	STORY						
Are you	u now, o	r have you ever been treated for an	ny of the following:			Allergies or	Reaction to	0:
Yes	No	Condition	Explain	Med	dication			
	<b>†</b>	Asthma		Foo	d. Plant	s, or Insect Bi	tes	
		Diabetes			ω, 			
		Hypertension (high blood pressur	re)			Immuniza	tions:	
		Heart disease (i.e., CHF, CAD, M		The	followin	g are recomme		e BSA.
	<u> </u>	Stroke/TIA				nunization mus	,	
	1	COPD				st 10 years. If h		
	<u> </u>	Ear/sinus problems				r. If immunized,	check the I	oox and
	$\top$	Muscular/skeletal condition			-	ar received.		
	†	Menstrual problems (women only	v)	Yes		Date		
		Psychiatric/psychological and emotional difficulties				Tetanus Pertussis		
		Learning disorders (i.e., ADHD, A	ADD)			Diptheria		
		Bleeding disorders				Measles		
	I	Fainting spells				Mumps Rubella		
	I	Thyroid disease				Polio		
		Kidney disease				Chicken pox		
		Sickle cell disease				Hepatitis A		
		Seizures				Hepatitis B		
		Sleep disorders (i.e., sleep apnea	a)			Influenza		
		GI problems (i.e., abdominal, dige	estive)	DE:	☐ Exemption to immunizations claimed.			
		Surgery			(For more information about immunizations, as			
	Serious injury			well as the immunization exemption form, see				
		Other		Sco	uting Sa	afely on <i>Scout</i>	ing.org.)	
List all		ations currently used. (If addition	onal space is needed, please pho cluded, even if they are for occas	sional or emerge	ency us	se only.		
			Medication		Medication			
Strength Frequency		· -	Strength Frequency		Strength Frequency			
Reaso	on for m	nedication	Reason for medication	Re	eason fo	r medication		
		data started	Approximate data started	<del>-</del>		ato dato starto		

Medication Frequency Reason for medication	Medication Frequency Reason for medication	Medication Frequency Reason for medication		
Approximate date started Temporary  Permanent	Approximate date started Temporary  Permanent	Approximate date started Temporary  Permanent		
Medication Frequency Reason for medication	Medication Frequency Reason for medication	Medication Frequency Reason for medication		
Approximate date started Temporary  Permanent	Approximate date started	Approximate date started		

## Part C

## Parental Informed Consent and Hold Harmless/Release Agreement

I understand that participation in Scouting activities involves a certain degree of risk. I have carefully considered the risk involved and have given consent for myself 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 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.

I approve the sharing of the information on this form with BSA volunteers and professionals who need to know of medical situations that might require special consideration for the safe conducting of Scouting 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.
☐ Without restrictions.
☐ With special considerations or restrictions (list)
Talent Release Form
I hereby assign and grant to the local council and the Boy Scouts of America the right and permission to use and publish the photographs/film/videotapes/electronic representations and/or sound recordings made of me or my child by the Boy Scouts of America, and I hereby release the Boy Scouts of America from any and all liability from such use and publication.
I hereby 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 Boy Scouts of America, and I specifically waive any right to any compensation I may have for any of the foregoing.
□ Yes □ No
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
Participant's signature
Parent/guardian's signature
Date
Attach copy of insurance card (front and back) here. If required by your state, use the space provided here for notarization.





2008 Printing

Part C Last name: \_\_\_\_\_ DOB: \_\_\_\_