# Part A: Informed Consent, Release Agreement, and Authorization

A

**Full name:** Joe Doe

**DOB:** 01/20/2003

**High-adventure base participants:**
Expedition/crew No.: _____
or staff position: _____

### Informed Consent, Release Agreement, and Authorization

I understand that participation in Scouting activities involves the risk of personal injury, including death, due to the physical, mental, and emotional challenges in the activities offered. Information about those activities may be obtained from the venue, activity coordinators, or your local council. I also understand that participation in these activities is entirely voluntary and requires participants to follow instructions and abide by all applicable rules and the standards of conduct.

In case of an emergency involving me or my child, I understand that efforts will be made to contact the individual listed as the emergency contact person by the medical provider and/or adult leader. 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 protected health information to the adult in charge, camp medical staff, camp management, and/or any physician or health-care provider involved in providing medical care to the participant. Protected Health Information/ Confidential Health Information (PHI/CHI) under the Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. §§160.103, 164.501, etc. seq., as amended from time to time, includes 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.

(If applicable) I have carefully considered the risk involved and hereby give my informed consent for my child to participate in all activities offered in the program. I further authorize the sharing of the information on this form with any BSA volunteers or professionals who need to know of medical conditions that may require special consideration in conducting Scouting activities.

**With appreciation of the dangers and risks associated with programs and activities, on my own behalf and/or on behalf of my child, I hereby fully and completely release and waive any and all claims for personal injury, death, or loss that may arise against the Boy Scouts of America, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with any program or activity.**

I also hereby assign and grant to the local council and the Boy Scouts of America, as well as their authorized representatives, the right and permission to use and publish the photographs/film/videotapes/electronic representations and/or sound recordings made of me or my child at all Scouting activities, and I hereby 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 liability from such use and publication. I further 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 BSA, and I specifically waive any right to any compensation I may have for any of the foregoing.

! **NOTE: Due to the nature of programs and activities, the Boy Scouts of America and local councils cannot continually monitor compliance of program participants or any limitations imposed upon them by parents or medical providers. However, so that leaders can be as familiar as possible with any limitations, list any restrictions imposed on a child participant in connection with programs or activities below.** !

**List participant restrictions, if any:** ■ **None**

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. If I am participating at Philmont, Philmont Training Center, Northern Tier, Florida Sea Base, or the Summit Bechtel Reserve, I have also read and understand the supplemental risk advisories, including height and weight requirements and restrictions, and understand that the participant will not be allowed to participate in applicable high-adventure programs if those requirements are not met. The participant has permission to engage in all high-adventure activities described, except as specifically noted by me or the health-care provider. If the participant is under the age of 18, a parent or guardian's signature is required.

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, California)**

## Complete this section for youth participants only:

### Adults Authorized to Take to and From Events:

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

Adult leaders going to camp.

Name: Gary Pan

Telephone: (cell) 703-598-3412

Name: Kevin Maxson

Telephone: (cell) 703-258-2869

### Adults NOT Authorized to Take Youth To and From Events:

Name: _____

Telephone: _____

Name: _____

Telephone: _____

# Part B: General Information/Health History

**B**

**Full name:** Joe Doe

**DOB:** 01/20/2003

**High-adventure base participants:**
Expedition/crew No.: _____
or staff position: _____

Age: 15 Gender: M Height (inches): 5 Weight (lbs.): 8

Address: 555 Main St.

City: Great Falls State: VA ZIP code: 22066 Telephone: 703-555-2355

Note: Girl's Troop, Please list Gary Pan as Unit leader, his mobile phone number is 703-598-3412

Unit leader: Jeff Ye Mobile phone: (571) 276-5394

Council Name/No.: National Capital Area Council Unit No.: 55

Health/Accident 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** ☐ **No** ☐ |
| ☐ | ☐ | List all surgeries and hospitalizations | **Last surgery date**: |
| ☐ | ☐ | List any other medical conditions not covered above | |

# Part B: General Information/Health History

**B**

**Full name:** Joe Doe

**DOB:** 01/20/2003

**High-adventure base participants:**
Expedition/crew No.: _____
or staff position: _____

## Allergies/Medications

Are you allergic to or do you have any adverse reaction to any of the following?

*Note: Inhalers and EpiPens must be current*

*Check expiration dates!!*

| Yes | No | Allergies or Reactions | Explain |
|---|---|---|---|
| ☐ | ☐ | Medication | |
| ☐ | ☐ | Food | |

| Yes | No | Allergies or Reactions | Explain |
|---|---|---|---|
| ☐ | ☐ | Plants | |
| ☐ | ☐ | 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 |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Note:**
**If you don't check "Yes" here, your child will not be given anything, even Tylenol, Aspirin etc. if need arises.**

* ☐ **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.** **!**

## Immunization - Full record

The following immunizations are recommended by the BSA. Tetanus immunization is required and must have been received within the last 10 years. If you had the disease, check the disease column and list the date. If immunized, check yes and provide the year received.

| Yes | No | Had Disease | Immunization | Date(s) |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | Tetanus **Important! Must be current** | |
| ☐ | ☐ | ☐ | Pertussis | |
| ☐ | ☐ | ☐ | Diphtheria | |
| ☐ | ☐ | ☐ | Measles/mumps/rubella | |
| ☐ | ☐ | ☐ | Polio | |
| ☐ | ☐ | ☐ | Chicken Pox | |
| ☐ | ☐ | ☐ | Hepatitis A | |
| ☐ | ☐ | ☐ | Hepatitis B | |
| ☐ | ☐ | ☐ | Meningitis | |
| ☐ | ☐ | ☐ | Influenza | |
| ☐ | ☐ | ☐ | Other (i.e., HIB) | |
| ☐ | ☐ | ☐ | Exemption to immunizations (**form required**) | |

**Please list any additional information about your medical history:**

**DO NOT WRITE IN THIS BOX**
Review for camp or special activity.

**Reviewed by:** _____

**Date:** _____

**Further approval required:** ☐ Yes ☐ No

**Reason:** _____

**Approved by:** _____

**Date:** _____

# Part C: Pre-Participation Physical

C

This part must be completed by certified and licensed physicians (MD, DO), nurse practitioners, or physician assistants.

**Full name:** Joe Doe

**DOB:** 01/20/2003

**High-adventure base participants:**
Expedition/crew No.: _____
or staff position: _____

**You are being asked to certify that this individual has no contraindication for participation inside a Scouting experience. For individuals who will be attending a high-adventure program, including one of the national high-adventure bases, please refer to the supplemental information on the following pages or the form provided by your patient.**

**Examiner: Please fill in the following information:**

| | Yes | No | Explain |
|---|---|---|---|
| * Medical restrictions to participate | ☐ | ☐ | |

| Yes | No | Allergies or Reactions | Explain | Yes | No | Allergies or Reactions | Explain |
|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Medication | | ☐ | ☐ | Plants | |
| ☐ | ☐ | Food | | ☐ | ☐ | Insect bites/stings | |

* **Height (inches):**_____ **Weight (lbs.):**_____ **BMI:**_____ **Blood Pressure:**_____/_____ **Pulse:**_____

| | Normal | Abnormal | Explain Abnormalities |
|---|---|---|---|
| Eyes | ☐ | ☐ | |
| Ears/nose/ throat | ☐ | ☐ | |
| Lungs | ☐ | ☐ | |
| Heart | ☐ | ☐ | |
| Abdomen | ☐ | ☐ | |
| Genitalia/hernia | ☐ | ☐ | |
| Musculoskeletal | ☐ | ☐ | |
| Neurological | ☐ | ☐ | |
| Other | ☐ | ☐ | |

## Examiner's Certification

I certify that I have reviewed the health history and examined this person and find no contraindications for participation in a Scouting experience. This participant (with noted restrictions):

| True | False | Explain |
|---|---|---|
| ☐ | ☐ | Meets height/weight requirements. |
| ☐ | ☐ | Does not have uncontrolled heart disease, asthma, or hypertension. |
| ☐ | ☐ | Has not had an orthopedic injury, musculoskeletal problems, or orthopedic surgery in the last six months or possesses a letter of clearance from his or her orthopedic surgeon or treating physician. |
| ☐ | ☐ | Has no uncontrolled psychiatric disorders. |
| ☐ | ☐ | Has had no seizures in the last year. |
| ☐ | ☐ | Does not have poorly controlled diabetes. |
| ☐ | ☐ | If less than 18 years of age and planning to scuba dive, does not have diabetes, asthma, or seizures. |
| ☐ | ☐ | **For high-adventure participants, I have reviewed with them the important supplemental risk advisory provided.** |

* **Examiner's Signature:**_____ * **Date:**_____

**Provider printed name:**_____

Address:_____

City:_____ State:_____ ZIP code:_____

Office phone:_____

**Height/Weight Restrictions**
If you exceed the maximum weight for height as explained in the following chart and your planned high-adventure activity will take you more than 30 minutes away from an emergency vehicle/accessible roadway, you may not be allowed to participate.

**Maximum weight for height:**

| Height (inches) | Max. Weight | Height (inches) | Max. Weight | Height (inches) | Max. Weight | Height (inches) | Max. Weight |
|---|---|---|---|---|---|---|---|
| 60 | 166 | 65 | 195 | 70 | 226 | 75 | 260 |
| 61 | 172 | 66 | 201 | 71 | 233 | 76 | 267 |
| 62 | 178 | 67 | 207 | 72 | 239 | 77 | 274 |
| 63 | 183 | 68 | 214 | 73 | 246 | 78 | 281 |
| 64 | 189 | 69 | 220 | 74 | 252 | 79 and over | 295 |

Scout's insurance card copy, write down the name and DOB

Scout name: John Doe

Birthday: 01/20/2003

(Copy of insurance card two side)