



# Registration Form

## Boy Scouts of America

Today's Date \_\_\_\_\_

Scout Name (Last): \_\_\_\_\_ (First): \_\_\_\_\_ (M. I.) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_ Date of Birth \_\_\_\_\_ Current Grade \_\_\_\_\_

E-Mail Address \_\_\_\_\_ Current Patrol \_\_\_\_\_

Any allergies, medical conditions, or required medications? \_\_\_\_\_ (if yes, list on medical form)

Were you a Cub Scout? \_\_\_\_\_ If yes, former Pack # \_\_\_\_\_ Highest rank achieved \_\_\_\_\_

Were you or are you currently a member of another Troop? \_\_\_\_\_ If yes, Troop # \_\_\_\_\_

Father's Name \_\_\_\_\_ Work Phone # \_\_\_\_\_

E-Mail \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Mother's Name \_\_\_\_\_ Work Phone # \_\_\_\_\_

E-Mail \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Parent's Home Phone (If different from Scout's) \_\_\_\_\_

Parent's Address (If different from Scout's) \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

Dues are \$75.00 per year for first Scout in each family, \$50.00 for each additional Scout.

*(Financial assistance is available if needed. See the Committee Chair or Scoutmaster for details.)*

*(If joining mid-year, see Committee Chair for pro-rated dues information)*

Please make checks payable to: **Boy Scouts Troop 128.**

Turn in check and completed form to the Committee Chair at next scheduled Troop meeting.



# PERSONAL HEALTH AND MEDICAL RECORD

## CLASS 1 AND CLASS 2

**Class 1 (update annually for all participants).** Activity: Day camp, overnight hike, or other programs not exceeding 72 hours, with level of activity similar to that of home or school. Medical care is readily available. Current personal health and medical summary (history) is attested by parents to be accurate. This form is filled out by all participants and is on file for easy reference.

**Class 2 (required once every 36 months for all participants under 40 years of age).** Activity: Resident camp or any other activity such as backpacking, tour camping, or recreational sports involving events lasting longer than 72 consecutive hours, with level of activity similar to that at home or school. Medical care is readily available.

**Note:** Some states require an **annual** precamp medical evaluation. Your BSA local council service center can advise you about the requirements for your state.

If your child has had a medical evaluation (**physical examination**) within the last 36 months, a copy of the results of this examination must be attached to the health history for all participants in a camping experience lasting longer than 72 consecutive hours. If a copy is not available, a physical examination (using the Class 2 section of this form) must be scheduled by a \*licensed health-care practitioner. This medical evaluation (physical examination) also is required if your child is currently under medical care, takes a prescribed medication, requires a medically prescribed diet, has had an injury or illness during the past 6 months that limited activity for a week or more, has ever lost consciousness during physical activity, or has suffered a concussion from a head injury.

\*Examinations conducted by licensed health-care practitioners, other than physicians, will be recognized for BSA purposes in those states where such practitioners may perform physical examinations within their legally prescribed scope of practice.

**THIS FORM IS NOT TO BE USED BY ADULTS OVER 40, BY HIGH-ADVENTURE PARTICIPANTS (USE FORM NO. 34412A), OR FOR NATIONAL SCOUT JAMBOREE (USE FORM NSJ-34412-01).**

### 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 \_\_\_\_\_

Business address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

If 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. \_\_\_\_\_

I give permission for full participation in BSA programs, subject to limitations noted herein.

**In case of emergency,** I understand every effort will be made to contact me (if participant is an adult, my spouse or next of kin). In the event I cannot 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).

Date \_\_\_\_\_ Signature of parent/guardian or adult \_\_\_\_\_

Date updated \_\_\_\_\_ Signature of parent/guardian or adult \_\_\_\_\_

Date updated \_\_\_\_\_ Signature of parent/guardian or adult \_\_\_\_\_

**Some hospitals require the parent/guardian signature to be notarized. Check with your BSA local council.**

NAME

TROOP

CAMP SITE

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

**ALLERGIES:** Food, medicines, insects, plants Yes  No  Explain: \_\_\_\_\_

<b>GENERAL INFORMATION:</b>	Yes	No		Yes	No		Yes	No
ADHD (Attention-Deficit								
Hyperactivity Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions/seizures	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>

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 affect or limit full participation in swimming, backpacking, hiking long distances, or playing strenuous physical games: \_\_\_\_\_

List equipment needed such as wheelchair, braces, glasses, contact lenses, etc.: \_\_\_\_\_

**Immunizations:** (Give date of last inoculation.)

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

### CLASS 2 MEDICAL EVALUATION

(Read additional requirements outlined on front of form.)

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, boating, and vigorous group games. Please review the health history with the participant for any interim changes. **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 \_\_\_\_\_

<b>Check box:</b>	N	Abn		N	Abn		N	Abn
Growth development	<input type="checkbox"/>	<input type="checkbox"/>	Teeth	<input type="checkbox"/>	<input type="checkbox"/>	Genitalia	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>	Cardiopulmonary system	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>
HEENT	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Neurobehavioral	<input type="checkbox"/>	<input type="checkbox"/>

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

#### Limitations

Activity restrictions \_\_\_\_\_

Diet restrictions \_\_\_\_\_

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

Licensed health-care practitioner\*

Address \_\_\_\_\_ Phone \_\_\_\_\_

City, State, Zip \_\_\_\_\_

**\*Examinations conducted by licensed health-care practitioners, other than physicians, will be recognized for BSA purposes in those states where such practitioners may perform physical examinations within their legally prescribed scope of practice.**

<b>INTERVAL RECORD</b>	<b>SCREENING EXAMINATION</b>	
Date, Time, Place, Etc.	(Findings, diagnoses, treatment, instructions, disposition, etc.)	By
#34414B		
PHOTOCOPYING THIS FORM IS PERMITTED.		



NAME

TROOP

CAMP SITE