



Colorado Boy Scout Camps Health & Medical Record

This form is valid for 24 months for persons under 40 years of age and 12 months for persons 40 years of age and older. Personal Health and Medical Record—Class 1 and 3

Instructions: By completing sections 1, 2, and 3, this form qualifies as a Class 1 medical history. By completing all sections (page 1 and 2); this form qualifies as a Class 2 or 3 medical record.

Who needs a Class 1? Anyone attending Cub Scout Day Camps and any overnight activities less than 72 hours.
Who needs a Class 3? Anyone attending a high Adventure Base or Boy Scout Camp (longer than 72 hours).

**NOTE: ALL
MEDICATIONS
MUST BE IN
ORIGINAL
CONTAINER WITH
PHARMACY LABEL!**

LAST NAME

FIRST INITIAL

ALLERGIES

UNIT # _____
SESSION # _____

1. Personal and Emergency Contact Information

Name: _____ Date of Birth: _____ Age: _____ Sex: _____
Address: _____ City, State, Zip _____ Phone: _____

Name of Mother/Guardian/Spouse: _____
Phone: _____ E-mail: _____
Address: _____
City, State, Zip: _____
Place of Employment: _____
Phone: _____

Name of Father/Guardian/Spouse: _____
Phone: _____ E-mail: _____
Address: _____
City, State, Zip: _____
Place of Employment: _____
Phone: _____

If above persons are not available in the event of an emergency, please contact:

Name: _____ Phone: _____ Name: _____ Phone: _____

**Adults authorized to take youth to and from the event:
(You must designate an adult. Please include phone number)**

Persons NOT authorized to take youth to and from the event:

2. Health History Information

Name of Primary Physician: _____
Phone: _____
City, State: _____
Medical Insurance Provider: _____
Carrier's Name: _____
Policy or Group Number: _____
Medicaid ID #: _____
Medications taken in the last 30 days: _____

Medications to be continued at event and dose: _____

Special Instruction related to any medications: _____

Any activities participant cannot participate in: _____

Food Allergies: _____
Plant Allergies: _____
Insect/Animal Allergies: _____
Other Allergies: _____

	YES	NO	Explain
Serious Illness			
Serious Injury			
Deformity			
Surgery			
Ears, Eyes			
Nose, Sinus			
Teeth/Tonsils			
Chest, Lungs			
Heart Murmur			
Rheumatic Fever			
Appendicitis			
Kidney or Urine			
Menstrual problems			
Hernia			
Back, Limbs, Joints			
Sleepwalking			
Nervous Conditions			
Other (explain)			
Diet Restrictions			

3. Parent/Minor Signature

This health history is correct so far as I know, and is up to date as of the last 90 days. The person herein described has permission to engage in all prescribed camp activities except as noted. Emergency Authorization: I hereby give permission to the medical personnel selected by the camp officials to order x-rays, routine tests and treatment for me or my child, as in the event I cannot be reached in an emergency. I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for me or my child as named above. I hereby give permission to transport me or my child for medical assistance. I hereby give permission to Boy Scouts of America to use photos, likenesses, and images of me for marketing and publicity purposes. This form may be photocopied for use at camp. I understand that I am responsible for payment of all medical treatments received from non-camp sources. I also give permission for the camp medical staff to administer over-the-counter medications to my child, that the physician has approved on page 2 of this form.

I also give permission for my child to go on trips away from camp premises, and to participate in all camp activities.

***Signature of parent or guardian (or participant if over 18): _____ Date: _____

***Signature of Minor: _____ Date: _____

Name of Camper _____

Pack # _____

Authorization for Administration of Medication

I hereby authorize the properly qualified health supervisor of the Ben Delatour Scout Ranch to administer the medication which is prescribed for

(Name of Camper)

Name of Medication: _____

Date Prescribed: _____

Directions for Usage: _____

Name of Medication: _____

Date Prescribed: _____

Directions for Usage: _____

Name of Medication: _____

Date Prescribed: _____

Directions for Usage: _____

Physician's Name: _____

Office Address: _____

24 Hour Telephone: _____

Date: _____

All medications must be in original prescription bottles with original pharmacy labels!