

Annual BSA Health and Medical Record

Part A

GENERAL INFORMATION

Name _____ Date of birth _____ Age _____ Male Female
 Address _____ Grade completed (youth only) _____
 City _____ State _____ Zip _____ Phone No. _____
 Unit leader _____ Council name/No. _____ Unit No. _____
 Social Security No. (optional; may be required by medical facilities for treatment) _____ Religious preference _____
 Health/accident insurance company _____ Policy No. _____

**ATTACH A PHOTOCOPY OF BOTH SIDES OF INSURANCE CARD (SEE PART C).
 IF FAMILY HAS NO MEDICAL INSURANCE, STATE "NONE."**

In case of emergency, notify:

Name _____ Relationship _____
 Address _____
 Home phone _____ Business phone _____ Cell phone _____
 Alternate contact _____ Alternate's phone _____

MEDICAL HISTORY

Are you now, or have you ever been treated for any of the following:

Yes	No	Condition	Explain
		Asthma	
		Diabetes	
		Hypertension (high blood pressure)	
		Heart disease (i.e., CHF, CAD, MI)	
		Stroke/TIA	
		COPD	
		Ear/sinus problems	
		Muscular/skeletal condition	
		Menstrual problems (women only)	
		Psychiatric/psychological and emotional difficulties	
		Learning disorders (i.e., ADHD, ADD)	
		Bleeding disorders	
		Fainting spells	
		Thyroid disease	
		Kidney disease	
		Sickle cell disease	
		Seizures	
		Sleep disorders (i.e., sleep apnea)	
		GI problems (i.e., abdominal, digestive)	
		Surgery	
		Serious injury	
		Other	

Allergies or Reaction to:

Medication _____
 Food, Plants, or Insect Bites _____

Immunizations:

The following are recommended by the BSA. Tetanus immunization must have been received within the last 10 years. If had disease, put "D" and the year. If immunized, check the box and enter the year received.

Yes	No	Date
<input type="checkbox"/>	<input type="checkbox"/>	Tetanus _____
<input type="checkbox"/>	<input type="checkbox"/>	Pertussis _____
<input type="checkbox"/>	<input type="checkbox"/>	Diphtheria _____
<input type="checkbox"/>	<input type="checkbox"/>	Measles _____
<input type="checkbox"/>	<input type="checkbox"/>	Mumps _____
<input type="checkbox"/>	<input type="checkbox"/>	Rubella _____
<input type="checkbox"/>	<input type="checkbox"/>	Polio _____
<input type="checkbox"/>	<input type="checkbox"/>	Chicken pox _____
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A _____
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B _____
<input type="checkbox"/>	<input type="checkbox"/>	Influenza _____

Exemption to immunizations claimed.

(For more information about immunizations, as well as the immunization exemption form, see Scouting Safely on Scouting.org.)

MEDICATIONS

List all medications currently used. (If additional space is needed, please photocopy this part of the health form.)

Inhalers and EpiPen information must be included, even if they are for occasional or emergency use only.

Medication _____ Strength _____ Frequency _____ Reason for medication _____ Approximate date started _____ Temporary <input type="checkbox"/> Permanent <input type="checkbox"/>	Medication _____ Strength _____ Frequency _____ Reason for medication _____ Approximate date started _____ Temporary <input type="checkbox"/> Permanent <input type="checkbox"/>	Medication _____ Strength _____ Frequency _____ Reason for medication _____ Approximate date started _____ Temporary <input type="checkbox"/> Permanent <input type="checkbox"/>
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NOTE: Be sure to bring medications in the appropriate containers, and make sure that they are NOT expired, including inhalers and EpiPens. You SHOULD NOT STOP taking any maintenance medication.

Emergency contact No.:

Allergies:

DOB:

Last name:

Part C

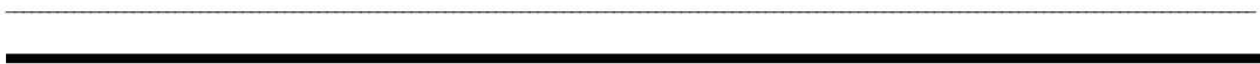
Parental Informed Consent and Hold Harmless/Release Agreement

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 _____
(if under the age of 18)

Date _____

Attach copy of insurance card (front and back) here. If required by your state, use the space provided here for notarization.



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<http://www.scouting.org>



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Part C **Last name:** _____ **DOB:** _____

**Peoria Park District & Camp Wokanda
Liability Waiver and Release of All Claims**

We are excited that you have chosen Camp Wokanda for your weekend trip. Camp Wokanda provides opportunities for a variety of activities, some of which include canoeing, fishing, hiking, archery, and camping. This form is vital in ensuring your safety and the safety of your child or ward. A Liability Waiver must be signed for any troop leader, volunteer or scout attending camp. It is the troop leader's responsibility to have all signed waivers upon arrival, so make sure to return this form as soon as possible to your leader. If you or your child need any special accommodations, the troop leader must know prior to arrival for arrangements with Camp Wokanda. The Peoria Park District will make reasonable accommodation to disabled individuals who meet essential eligibility requirements for the trip to Camp Wokanda.

Program _____

Date(s) of Trip _____ Emergency Phone _____

Participant _____

Address _____

City _____ Zip Code _____

Special
Accommodations _____

Please read this form carefully and be aware in registering yourself, your child, or ward for participation in this program, you will be waiving and releasing all claims for injuries you or your minor child/ward might sustain arising out of this program.

As a participant in the program or the parent/guardian of a participant in the program, I recognize and acknowledge that there are certain risks of physical injury and I agree to assume the full risk of any injuries, including death, damages, or loss which I or my minor child/ward may sustain as a result of participating in any or all activities connected with or associated with such program.

I agree to waive and relinquish all claims my minor child/ward or I may have as a result of participating in the program against the Peoria Park District and its officers, agents, servants, and employees.

I do hereby fully release and discharge the Peoria Park District and its officers, agents, servants, and employees from injuries, including death, damage, or loss which I or my minor child/ward may have or which may accrue to me or my minor child/ward on account of my participation in the program.

I further agree to indemnify, hold harmless and defend the Park District and its officers, agents, servants, and employees from any and all claims associated with the activities of the program.

In case of accident or sickness, I consent to emergency medical care provided by ambulance or hospital personnel.

I hereby consent to the use of my photograph in Park District brochures, publications, slide presentations, etc.

I have read and fully understand the above Waiver and Release of All Claims.

Date

Signature of Participant or Parent/Guardian