Part A: Informed Consent, Release Agreement, and Authorization

A

Full name: _____

Date of birth: _____

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.

Every person who furnishes any BB device to any minor, without the express or implied permission of the parent or legal guardian of the minor, is guilty of a misdemeanor. (California Penal Code Section 19915[a]) My signature below on this form indicates my permission.

I give permission for my child to use a BB device. (Note: Not all events will include BB devices.)

☐ **Checking this box indicates you DO NOT want your child to use a BB device.**

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 Scout Ranch, Philmont Training Center, Northern Tier, 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)

Complete this section for youth participants only:

Adults Authorized to Take Youth to and From Events:

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

Name: _____ Name: _____

Phone: _____ Phone: _____

Adults NOT Authorized to Take Youth to and From Events:

Name: _____ Name: _____

Phone: _____ Phone: _____

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Part B1: General Information/Health History

B1

Full name: _____

Date of birth: _____

High-adventure base participants:

Expedition/crew No.: _____

or staff position: _____

Age: _____ Gender: _____ Height (inches): _____ Weight (lbs.): _____

Address: _____

City: _____ State: _____ ZIP code: _____ Phone: _____

Unit leader: _____ Unit leader's mobile #: _____

Council Name/No.: _____ Unit No.: _____

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:** **Insulin pump: Yes** ☐ **No** ☐
☐	☐	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/reactive airway disease	**Last attack date:**
☐	☐	Lung/respiratory disease	
☐	☐	COPD	
☐	☐	Ear/eyes/nose/sinus problems	
☐	☐	Muscular/skeletal condition/muscle or bone issues	
☐	☐	Head injury/concussion/TBI	
☐	☐	Altitude sickness	
☐	☐	Psychiatric/psychological or emotional difficulties	
☐	☐	Neurological/behavioral disorders	
☐	☐	Blood disorders/sickle cell disease	
☐	☐	Fainting spells and dizziness	
☐	☐	Kidney disease	
☐	☐	Seizures or epilepsy	**Last seizure date:**
☐	☐	Abdominal/stomach/digestive problems	
☐	☐	Thyroid disease	
☐	☐	Skin issues	
☐	☐	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 B2: General Information/Health History

B2

Full name: _____

Date of birth: _____

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

Allergies/Medications

DO YOU USE AN EPINEPHRINE AUTOINJECTOR? ☐ YES ☐ NO Exp. date (if yes) _____

DO YOU USE AN ASTHMA RESCUE INHALER? ☐ YES ☐ NO Exp. date (if yes) _____

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

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 list on a separate sheet and attach.

Medication	Dose	Frequency	Reason

☐ 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

The following immunizations are recommended. 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	
☐	☐		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: _____

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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: _____

Date of birth: _____

High-adventure base participants:

Expedition/crew No.: _____

or staff position: _____

You are being asked to certify that this individual has no contraindication for participation in 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. You can also visit www.scouting.org/health-and-safety/ahmr to view this information online.

Please fill in the following information:

	Yes	No	Explain
Medical restrictions to participate	☐	☐	

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

Yes	No	Allergies or Reactions	Explain
☐	☐	Plants	
☐	☐	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	☐	☐	
Skin issues	☐	☐	
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.
☐	☐	Has no uncontrolled heart disease, lung disease, 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 planning to scuba dive, does not have diabetes, asthma, or seizures.

Examiner's signature: _____ **Date:** _____

Examiner's 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

Food Allergy and Religious Dietary Information Form

The Food Services Program Area at Hawk Mountain Scout Reservation is committed to insuring that your Scout has the best meals that we can provide. We understand that many children are allergic to foods that we use every day in the kitchen or that they may follow dietary guidelines of their religion.

If your Scout has any allergies to food or follows dietary guidelines of their religion, please complete the form below. This form is very important to the Food Services Program Area. In order for your Scout to have adequate food, we need to be aware of any dietary needs. It is also very important for us to know if the Scout has a severe allergy, so that we may do everything that we are able to ensure the Scout does not come in contact with that particular food. Please take the time to answer the few questions below.

You also have the option of providing your Scout's meals. If this is chosen, the meal costs ($3-Breakfast; $4.50-Lunch; $5-Dinner) will be deducted from the camper fee.

Sign and return the form no later than two weeks prior to your Scout's camping week. *Forms given on Sunday of that week of camp will be accepted but provisions may not be available. This form is required in advance so food can be purchased to assist the needs of the Scout.* Mail the form to Hawk Mountain Council, ATTN: Food Services Program Area, 5027 Pottsville Pike, Reading, PA 19605.

NAME: _____ TROOP/PACK: _____

Date/Week attending camp: _____

Food Allergies: YES NO (Please check one)

What are they: _____

How severe is the Allergy: MODERATE STRONG SEVERE (Please choose one)

Any other information we need to know? _____

_____

Religious Needs: YES NO (Please circle one)

What can we do to help? _____

_____

I choose / do not choose (Please choose one) to provide meals for my Scout.

Parent/Guardian Signature _____ Date _____
Phone Number _____ E-mail _____

Hawk Mountain Scout Reservation
Over-The-Counter Medications

Name of Camper: _____ Age: _____

Unit Number: _____ Camp Site Name: _____

Hawk Mountain Scout Reservation Health Lodge has the following medications available for campers. As the Parent or Legal Guardian you can give permission for the Health Lodge Medical officer to administer any of the following medications by placing your initials in the column next to the appropriate medication.

Name of Medication	Initial of Parent to Allow the Health Officer To Administer Medication
Tylenol, Regular Strength	
Tylenol, Chewable	
Tylenol Cold	
Pepto-Bismol Regular Strength	
Mylanta	
Benadryl Allergy	
Sudafed	
Robitussin Liquid	
Cepacol	
Ibuprofen	
Alka-Seltzer	
Tums Anti-acid	
Hydrocortisone Anti-Itch Cream	

NOTE: The items listed above will be under lock and key at the Health Lodge. If there are any over-the counter medications that are not on the list and need to be available, please add them in the blank spaces and initial the second column.

As Parent or Legal Guardian of the above named camper, I give the Health Lodge Medical officer permission to administer ONLY the medications that I have initialed in the column next to the medication. I understand that if I have not initialed the item, the Health Lodge Medical officer may not administer that medication.

Date: _____ 20_____ Signature of Parent or Legal Guardian _____

As Parent or Legal Guardian of the above named camper, I do NOT give permission for the Health Lodge Medical officer to administer any over-the-counter medications. In the event that the camper needs one of the medications, the Health Lodge Medical officer will contact one of the Parents or Legal Guardians. Please give the Health Lodge Medical officer the following information:

Name of Parent or Legal Guardian: _____

Day Time Phone Number: _____

Night Time Phone Number: _____

Date: _____ 20_____ Signature of Parent or Legal Guardian _____

Routine Drug Administration Record

Name: ____________ Campsite: ____________

Troop No.: ____________ Date of birth: ____________ Classification: ____________

Drug hypersensitivity: ____________ Weight: ____________

Prescribing Physician: ______________________________
Medications: ______________ Rx: ☐ No ☐ Yes Number(s): ______
Dosage: __________________________ Date filled: ______________
Route: ☐ P.O. ☐ I.M. ☐ S.C. ☐ S.L. ☐ Topical ☐ Inhalation ☐ Rectal
Times: ☐ PRN ☐ Daily ☐ B.I.D. ☐ T.I.D. ☐ Q.I.D. ☐ A.C. ☐ P.C. ☐ H.S.
Amount in bottle: ______________ Comments: __________________

Med Time	S	M	T	W	T	F	S

Prescribing Physician: ______________________________
Medications: ______________ Rx: ☐ No ☐ Yes Number(s): ______
Dosage: __________________________ Date filled: ______________
Route: ☐ P.O. ☐ I.M. ☐ S.C. ☐ S.L. ☐ Topical ☐ Inhalation ☐ Rectal
Times: ☐ PRN ☐ Daily ☐ B.I.D. ☐ T.I.D. ☐ Q.I.D. ☐ A.C. ☐ P.C. ☐ H.S.
Amount in bottle: ______________ Comments: __________________

Med Time	S	M	T	W	T	F	S

Prescribing Physician: ______________________________
Medications: ______________ Rx: ☐ No ☐ Yes Number(s): ______
Dosage: __________________________ Date filled: ______________
Route: ☐ P.O. ☐ I.M. ☐ S.C. ☐ S.L. ☐ Topical ☐ Inhalation ☐ Rectal
Times: ☐ PRN ☐ Daily ☐ B.I.D. ☐ T.I.D. ☐ Q.I.D. ☐ A.C. ☐ P.C. ☐ H.S.
Amount in bottle: ______________ Comments: __________________

Med Time	S	M	T	W	T	F	S

Prescribing Physician: ______________________________
Medications: ______________ Rx: ☐ No ☐ Yes Number(s): ______
Dosage: __________________________ Date filled: ______________
Route: ☐ P.O. ☐ I.M. ☐ S.C. ☐ S.L. ☐ Topical ☐ Inhalation ☐ Rectal
Times: ☐ PRN ☐ Daily ☐ B.I.D. ☐ T.I.D. ☐ Q.I.D. ☐ A.C. ☐ P.C. ☐ H.S.
Amount in bottle: ______________ Comments: __________________

Med Time	S	M	T	W	T	F	S

Prescribing Physician: ______________________________
Medications: ______________ Rx: ☐ No ☐ Yes Number(s): ______
Dosage: __________________________ Date filled: ______________
Route: ☐ P.O. ☐ I.M. ☐ S.C. ☐ S.L. ☐ Topical ☐ Inhalation ☐ Rectal
Times: ☐ PRN ☐ Daily ☐ B.I.D. ☐ T.I.D. ☐ Q.I.D. ☐ A.C. ☐ P.C. ☐ H.S.
Amount in bottle: ______________ Comments: __________________

Med Time	S	M	T	W	T	F	S

P.O. = by mouth   I.M. = intermuscular   S.C. = sub-cutaneous   S.L. = sub-lingual-under-tongue
PRN = as needed   B.I.D. = two times a day   T.I.D. = three times a day   Q.I.D. = four times a day
A.C. = before meals   P.C. = after meals   H.S. = hours of sleep (taken at bedtime)

Initial	Signature	Name	Position

INSTRUCTIONS: Sheet is for reproduction as needed. It should be three-hole punched and kept in a binder during camp week. Use one sheet for each camper with a prescription. Record all medicines brought to camp (up to FIVE medications per sheet). The medication, dosage and dosage schedule should be copied from the prescription. Record dispensing times and days in the blocks provided for each medication as they are dispensed. After camp, place sheet(s) inside the first aid log.