



# Boston Minuteman Council Boy Scouts of America Medical Form



Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ DOB \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Pack/Troop Number \_\_\_\_\_ Community \_\_\_\_\_  
 Parent's Name \_\_\_\_\_ Home Phone # (\_\_\_\_) \_\_\_\_\_  
 Work Phone # (\_\_\_\_) \_\_\_\_\_ Cell Phone #/Pager # (\_\_\_\_) \_\_\_\_\_  
 Emergency contact:  
 Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

1. Are you/Is your child under the care of a physician for any on going medical conditions  
 \_\_\_ Yes \_\_\_ No
2. Are there any current health problems? \_\_\_ Yes \_\_\_ No
3. Are any medications being taken on a regular basis? \_\_\_ Yes \_\_\_ No
4. Has there been any surgery, injury, allergy or change in health since the last physical exam ?  
 \_\_\_ Yes \_\_\_ No

Is there disease of (or past or present history of):

	Y/N		Y/N		Y/N
Serious illness	___	Chest, Lungs	___	Limbs, Joints	___
Serious injury	___	Heart, Murmurs	___	Hernia (Rupture)	___
Rheumatic fever	___	Nervous cond.	___	Surgery	___
Stomach, Bowels	___	Sleep walking	___	Skin, Glands	___
Appendicitis	___	Bed wetting	___	Ears, Eyes	___
Kidneys, Urine	___	ADD/ADHD	___	Nose, Sinus	___
Albumin, Sugar	___	Hernia	___	Other _____	
Throat, Tonsils	___	Infection	___	_____	
Teeth, Dentures	___			_____	

Dates/ Details of any YES answer \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Additional information: i.e. Difficulty making friends, shy, emotional, social/family issues.  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

# Healthcare Provider Form

Please completely fill out this form (you may attach a copy of your own form, but please fill in any missing information.)

\* Please sign this form even if you attach your own form \*

ALLERGY TO MEDICATIONS OR FOODS: \_\_\_\_\_  
Allergy to plant or animal or insect toxin: \_\_\_\_\_  
Reaction: \_\_\_\_\_  
Treatment needed: \_\_\_\_\_

Immunizations: under 18  
D.T.P. (5 doses) \_\_\_\_\_  
MMR (2 doses) \_\_\_\_\_  
Polio (4 doses) \_\_\_\_\_  
Heb B (3 doses if born after 1/1/92) \_\_\_\_\_  
Varivax \_\_\_\_\_ (or month and year of disease \_\_\_\_\_)  
TD booster (within 10 years) \_\_\_\_\_  
Hib \_\_\_\_\_

Immunization: 18 and over  
Measles live vaccine 2 doses  
\_\_\_\_\_  
(unless born before 1957)  
Mumps vaccine 1 dose \_\_\_\_\_  
(unless born before 1957)  
Rubella vaccine \_\_\_\_\_  
TD booster (within 10 years) \_\_\_\_\_

Examination findings:  
Ht. \_\_\_\_\_ Wt. \_\_\_\_\_ B/P \_\_\_\_\_ Pulse \_\_\_\_\_  
Vision: Normal \_\_\_\_\_ Glasses \_\_\_\_\_ Contacts \_\_\_\_\_  
Hearing: Normal \_\_\_\_\_ Abnormal \_\_\_\_\_ Hearing Aides \_\_\_\_\_

Physical Findings: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please note any abnormal physical findings and specify any physical or dietary limitations.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Approved for participation in: All activities \_\_\_\_\_ Hiking and camping \_\_\_\_\_ Water activities \_\_\_\_\_  
Competitive sports \_\_\_\_\_ Restrictions \_\_\_\_\_

Medications needed at camp Yes \_\_\_\_\_ No \_\_\_\_\_ **If yes please fill out a medication order form. A Physician's order is needed for ALL medications, even over the counter ones...i.e. Acetaminophen, Ibuprofen.**

Signed \_\_\_\_\_ M.D./D.O./P.A./NP Date \_\_\_\_\_  
Office Phone # ( \_\_\_\_\_ ) \_\_\_\_\_

**\*Please sign this form even if you attach your own form.\***

# Prescription and over the counter medication orders.

In order for the Nurse or member of the camp staff to administer medication at Camp, the following must be supplied:

1. This medical form signed and dated by healthcare provider and parent or guardian.
2. A one-week supply of the medication.
3. Over the counter medications need to be in original container. Prescription medication needs to be in a pharmacy labled container.

Medication \_\_\_\_\_  
Dosage \_\_\_\_\_ Route \_\_\_\_\_ Frequency \_\_\_\_\_  
Possible side effects or adverse reactions \_\_\_\_\_  
Duration of usage \_\_\_\_\_

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Possible side effects or adverse reactions \_\_\_\_\_  
Duration of usage \_\_\_\_\_

## Parent Permission

Permission to be at camp. Dates at camp \_\_\_\_\_

1. I, the undersigned, give my child, named on the first page, permission to attend one of Boston Minuteman Council's camping programs. I give him permission to fully participate in all camp programs, except as noted on this medical form. I understand that in order to attend he must submit this medical form correctly completed. I understand that a health care provider indicating that the camper has undergone a physical examination within one year of attending camp must sign the medical form.

2. I understand that in the event of an illness or injury at camp, every attempt will be made to contact me. In the event I can't be reached, I hereby give permission to the physician elected by the adult leader in charge to secure proper treatment, which may include hospitalization, anesthesia, surgery or administration of medication to my child.\*

3. I do hereby grant permission for the use of pictures, video or likeness of my child, taken during camp, to be used for promotional purposes.

4. Medical Insurance: Provider \_\_\_\_\_ ID Number \_\_\_\_\_

I have carefully read and understand all sections of this permission slip.

Parent Signature \_\_\_\_\_ Print Name \_\_\_\_\_

Date \_\_\_\_\_ ( Must be signed if applicant is under 18)

\* If your religion prohibits certain medical procedures, please contact the Council Office for a waiver form.

If your son is going to be transported home by someone other than yourself please note the persons name below:

Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**For Cub and Webelos Resident Camp only** My child has a pocket knife for use during Scout Craft. Yes \_\_\_ No \_\_\_  
All pocket knives need to have the child's name written on a piece of tape. The knives need to be turned in at camp at registration and they will be held by the Adult leaders.

Applicant's signature \_\_\_\_\_ Date \_\_\_\_\_  
( Must be signed if applicant is 18 or over )

