

Adult Medical Forms

The following documents will need to be submitted to Camp Alexander prior to arrival. Each unit will have ONE leader responsible for submitting documents.

1. BSA Medical Form (Parts A, B1, B2, AND C) – please note that if medication is being taken a doctor’s signature is required on B2, if no medication is being taken only the parent signature is required.
2. Copy of Health Insurance Card
3. Adult Reference forms for each leader – will be submitted with whole unit forms.

Part A: Informed Consent, Release Agreement, and Authorization

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: _____



Part B1: General Information/Health History

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 <input type="checkbox"/> No <input type="checkbox"/> |
| | | Hypertension (high blood pressure) | |
| | | Adult or congenital heart disease/heart attack/chest pain (anginal)/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 <input type="checkbox"/> No <input type="checkbox"/> |
| | | List all surgeries and hospitalizations | Last surgery date: _____ |
| | | List any other medical conditions not covered above | |



Part B2: General Information/Health History

Full name: _____

Date of birth: _____

High-adventure base participants:

Expedition/crew No.: _____
or staff position: _____

Allergies/Medications

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

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

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

| Yes | No | Allergies or Reactions | Explain | Yes | No | Allergies or Reactions | Explain |
|-----|----|------------------------|---------|-----|----|------------------------|---------|
| | | Medication | | | | Plants | |
| | | Food | | | | 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: _____



Part C: Pre-Participation Physical

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.

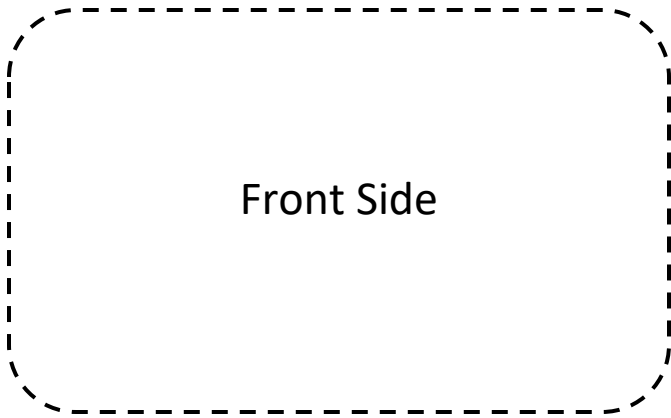
Maximum weight for height:

| 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 |

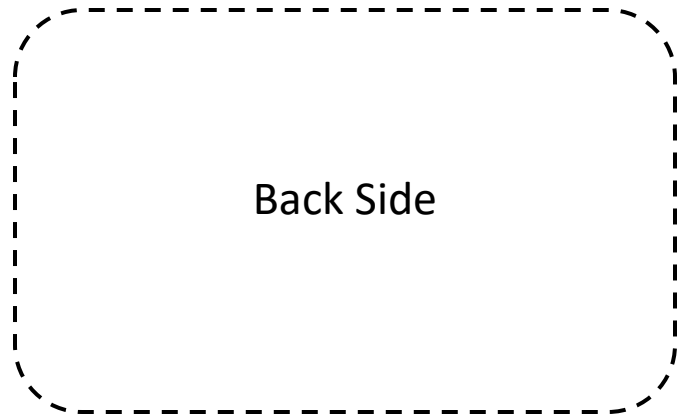


Prepared. For Life.®

Copy of Health Insurance Card



Front Side



Back Side

Please include a front and back copy of your health insurance card.

If you do not have health insurance, please check the box below.

- I do not have health insurance and can therefore not provide a copy of a health insurance card.

EVERY ADULT LEADER ATTENDING CAMP ALEXANDER SUMMER CAMP MUST COMPLETE THIS LEADER REFERENCE FORM:

PURSUANT TO: COLORADO DEPARTMENT OF HUMAN SERVICES,
MINIMUM RULES AND REGULATIONS FOR CHILDREN'S CAMPS
GENERAL REQUIREMENTS FOR ALL PERSONNEL 7.711.21D & GENERAL RULES 7.701.53A

LEADER NAME: _____ TROOP NUMBER: _____
COUNCIL _____ DATE ATTENDING CAMP: _____

THIS FORM IS TO BE FILLED OUT BY ANY ADULT WHO WILL BE SPENDING A NIGHT AT CAMP ALEXANDER DURING OUR SUMMER CAMPING SEASON.

1. ROLE OF THE ADULT LEADER IN CAMP:

It is the role of the adult leader to supervise and monitor the youth in their unit. Unit leaders shall not have any other duties that would detract from the responsibility of service as a leader.

2. CHARGES OR CONVICTIONS:

Have you ever been charged with or convicted of any charges of child abuse or neglect, unlawful sexual offense, or any felony?

Check one YES NO

3. UNDERSTANDING & REPORTING OF CHILD ABUSE:

Child abuse consists of a wide variety of different problems. Usually these are categorized as physical abuse, emotional abuse, sexual abuse and neglect. Physical abuse is the injury of the child by other than accidental means. Emotional abuse is the constant belittling, criticizing, yelling at and verbal tearing down of the child. Sexual abuse is any sexual activity between a child and an adult, or sexual activity involving children in which the age, size or other power factors between the participants is unequal. Child neglect is failure to provide necessary nurturance when resources are available to do so.

Under the "Child Protection Act of 1987" (C.R.S. 19-3-301) in the Colorado Children's Code, leaders are required to report suspected child abuse or neglect. The law at 19-3-304 states that if a leader has "reasonable cause to know or suspect that a child has been subjected to abuse or neglect or who has observed the child being subjected to circumstances or conditions which would reasonably result in abuse or neglect shall immediately report" such information to the Camp Director. It is not the leader's role to investigate suspected abuse – only to report it. Persons who make a good faith report are immune from civil and criminal liability. Additionally, the law provides for the protection of the identity of the reporting party.

A leader who fails to report suspected child abuse or neglect commits a class 3 misdemeanor and will be punished as provided in section 18-1-106, C.R.S.

I have read and understand the above requirements concerning my responsibility regarding child abuse reporting, and my role of the adult leader in camp.

Signature _____ Date _____

CHARACTER REFERENCE #1:

This section to be completed by an individual who knows the adult and who can provide a frank evaluation of the adult's suitability in working with children during a week-long camp.

CHECK THE WORD THAT BEST DESCRIBES THE ADULT LEADER

ATTITUDE: ENTHUSIASTIC POSITIVE ACCEPTABLE NEGATIVE
COMMON SENSE: ALWAYS SOUND USUALLY SOUND NEEDS DIRECTION NONE
INTEGRITY: TRUSTWORTHY USUALLY RELIABLE LACKING

WOULD YOU TRUST THE CARE OF YOUR CHILD WITH THIS PERSON? YES NO
I RECOMMEND THIS PERSON AS AN ADULT LEADER: YES NO

SIGNATURE _____ DATE _____

PRINTED NAME _____ PHONE # _____

CHARACTER REFERENCE #2:

This section to be completed by an individual who knows the adult and who can provide a frank evaluation of the adult's suitability in working with children during a week-long camp.

CHECK THE WORD THAT BEST DESCRIBES THE ADULT LEADER

ATTITUDE: ENTHUSIASTIC POSITIVE ACCEPTABLE NEGATIVE
COMMON SENSE: ALWAYS SOUND USUALLY SOUND NEEDS DIRECTION NONE
INTEGRITY: TRUSTWORTHY USUALLY RELIABLE LACKING

WOULD YOU TRUST THE CARE OF YOUR CHILD WITH THIS PERSON? YES NO
I RECOMMEND THIS PERSON AS AN ADULT LEADER: YES NO

SIGNATURE _____ DATE _____

PRINTED NAME _____ PHONE # _____

CHARACTER REFERENCE #3:

This section to be completed by an individual who knows the adult and who can provide a frank evaluation of the adult's suitability in working with children during a week-long camp.

CHECK THE WORD THAT BEST DESCRIBES THE ADULT LEADER

ATTITUDE: ENTHUSIASTIC POSITIVE ACCEPTABLE NEGATIVE
COMMON SENSE: ALWAYS SOUND USUALLY SOUND NEEDS DIRECTION NONE
INTEGRITY: TRUSTWORTHY USUALLY RELIABLE LACKING

WOULD YOU TRUST THE CARE OF YOUR CHILD WITH THIS PERSON? YES NO
I RECOMMEND THIS PERSON AS AN ADULT LEADER: YES NO

SIGNATURE _____ DATE _____

PRINTED NAME _____ PHONE # _____