2005 NATIONAL SCOUT JAMBOREE, BOY SCOUTS OF AMERICA
HEALTH AND MEDICAL RECORD

(Complete after October 1, 2004)

Important: Do not fold, tear, or staple this form.

Please write legibly and fill in all fields. MAKE COPIES FOR YOURSELF. Original form must be returned. Photocopies will not be accepted.

I. IDENTIFICATION

Name _____ _____ _____ _____

Last name First name Middle Name Date of birth (MM/DD/YYYY) Age Sex

Participant ❑ Staff ❑ Council number _____ Regional subcamp or national _____

Address _____

City _____ State _____ Zip code _____

Health/accident insurance company _____ Policy number _____ Religious preference _____

Scoutmaster _____ Personal physician _____ Phone number (____) _____

Home council name _____ City/state _____

IN CASE OF AN EMERGENCY:

Name _____ Relationship _____

Address _____

City _____ State _____ Zip code _____

Home phone (____) _____ Business phone (____) _____ Extension (____) _____

II. EMERGENCY MEDICAL INFORMATION

Has or is subject to: (If yes, explain below.)

Yes	No		Yes	No		Yes	No		Yes	No	
❑	❑	Attention Deficit Hyperactivity Disorder	❑	❑	Asthma	❑	❑	Contact lens	❑	❑	Fainting spells
❑	❑	Bleeding disorders	❑	❑	Dentures	❑	❑	Heart trouble	❑	❑	Convulsions
❑	❑	Diabetes	❑	❑	Hypertension						
❑	❑	Any condition that may require special care, medication or diet									
❑	❑	Allergy to a medicine, food, plant, animal, or insect toxin									

EXPLAIN: _____

_____

III. IMMUNIZATIONS

For youth (under 18) required immunizations: Tetanus and diphtheria toxoids, measles, mumps and rubella, chicken pox (disease or immunization), and polio. For youth (under 18) recommended immunizations: measles booster at age 12 and hepatitis A and B. Youth and adults require a tetanus booster within 10 years. If had disease, put "D" and year of the disease. If immunized, check the box and put the year of the immunization.

Yes	No		Yes	No	
❑	❑	Tetanus	❑	❑	Rubella
❑	❑	Diphtheria	❑	❑	Polio
❑	❑	Pertussis	❑	❑	Chicken pox
❑	❑	Measles	❑	❑	Hepatitis A
❑	❑	Mumps	❑	❑	Hepatitis B

THIS SPACE FOR OFFICE USE ONLY

Satisfaction of jamboree immunization requirements MUST BE CONFIRMED by council contingent leadership at least 30 days prior to arrival on site, and verified by jamboree medical personnel at check-in.

Name (Please print) _____

Signature _____ Date _____

IV. MEDICAL HISTORY

Check immunization to be given at this time. Be sure to include any emergency information and restrictions or special care that should be observed. Especially be sure to record any injuries, illness, surgery, or significant changes in condition of health of applicant since last complete examination. Are you aware of any current health problems? Yes ❑ No ❑

Has there been any surgery, injury, illness, allergy, or change in health status since last complete physical examination? Yes ❑ No ❑

Is there history or current disease or problem regarding: (For any "yes" answers give dates and full details below.)

	Yes	No	Year	Explain		Yes	No	Year	Explain
Serious illness	❑	❑	____	_____	Stomach, bowels	❑	❑	____	_____
Serious injury	❑	❑	____	_____	Appendicitis	❑	❑	____	_____
Deformity	❑	❑	____	_____	Kidneys or urine	❑	❑	____	_____
Surgery	❑	❑	____	_____	Albumin	❑	❑	____	_____
Skin, glands	❑	❑	____	_____	Sugar	❑	❑	____	_____
Ears, eyes	❑	❑	____	_____	Infection	❑	❑	____	_____
Nose, sinus	❑	❑	____	_____	Bed-wetting	❑	❑	____	_____
Teeth, tonsils	❑	❑	____	_____	Menstrual problems	❑	❑	____	_____
Dentures	❑	❑	____	_____	Hernia (rupture)	❑	❑	____	_____
Bridge	❑	❑	____	_____	Back, limbs, joints	❑	❑	____	_____
Chest, lungs	❑	❑	____	_____	Sleepwalking	❑	❑	____	_____
Heart	❑	❑	____	_____	Nervous condition	❑	❑	____	_____
Murmur	❑	❑	____	_____	Attention deficit disorder	❑	❑	____	_____
Rheumatic fever	❑	❑	____	_____	Other	❑	❑	____	_____

V. PARENTAL OR ADULT PARTICIPANT STATEMENT

Has it ever been necessary to restrict applicant's activities for medical reasons? Yes ❑ No ❑

If yes, EXPLAIN _____

Does applicant take medicine (prescription or over the counter) on a regular basis? Yes ❑ No ❑

If yes, please list in detail:

Drug	Dosage	Route (Example: oral, injection, etc.)	Frequency

To the best of my knowledge, the information in sections I, II, III, IV, and V is accurate and complete. I request licensed health care practitioner to examine applicant, to give needed immunization, and to furnish requested information to other agencies as needed. I give my permission for full participation in the Jamboree, subject to limitations noted herein. In the event of illness or accident in the course of such activity, I request that measures be initiated without delay as judgment of medical personnel dictates.

Parent or guardian must sign if applicant is under 18:

Parent or guardian _____ Date signed _____

Applicant's signature _____ Date signed _____

IMMEDIATELY BEFORE THE JAMBOREE, PLEASE COMPLETE THIS SECTION.

During the 30 days preceding the jamboree, has applicant taken any medication (prescription or non-prescription) that is NOT listed above?

Yes ❑ No ❑ If yes, list in detail: drug, dose, and date taken _____

_____

_____

_____

VI. HEALTH EXAMINATION

Licensed health care practitioner:

The applicant will be participating in a strenuous activity that will include one or more of the following conditions: high heat and humidity, high air particle count, more walking than normal, fatigue, and physical competition. Please be advised that electricity, air conditioning and any special diets will not be available at the site. Exposure to bee stings, ticks, and poisonous plants is very likely.

Please insist applicant furnish complete medical history (section IV of this form) before examination.

Review immunizations. For youth (under 18) **required** immunizations: tetanus and diphtheria toxoids, measles, mumps and rubella, chicken pox, and polio. For youth (under 18) **recommended** immunizations: A measles booster at age 12 and hepatitis A and B. For youth and adults, a tetanus booster within 10 years is required.

Date: _____

Height_____ Weight_____ Blood pressure_____ /_____ Pulse_____

VISION: Normal _____ Glasses_____ Contacts_____

HEARING: ❑ Normal ❑ Abnormal

LABORATORY (if indicated): Fasting blood glucose_____ Hemoglobin_____ Urine_____

Mark below **if abnormal**, and give details below:

❑ Growth, development	❑ Skin, glands, hair	❑ Head, neck, thyroid	❑ Eyes, ears, nose
❑ Teeth, tonsils	❑ Respiratory	❑ Cardiovascular	❑ Abdomen, hernia, rings
❑ Genitourinary	❑ Musculoskeletal	❑ Neuropsychiatric	❑ Other (specify)_____

COMMENTS: See Medical Alert section and use if applicable.

VII. LICENSED HEALTH CARE PRACTITIONER'S EVALUATION AND ADVICE

Approved for participation in: ❑ Hiking and camping ❑ Competitive activities ❑ Sports/water activities ❑ All activities

Specify exceptions _____

Recommendations (Explain any restrictions or limitations; see medical alert section, and use if applicable.): _____

_____

_____

_____

_____

_____

_____

_____

_____

Physician's name (please print)_____ Phone (_____) _____

Address _____

City _____ State_____ Zip code _____

Signature of licensed health care practitioner*_____ Date _____

License No._____ State_____ Expiration date_____

*Examinations conducted by licensed health care practitioners other than physicians will be recognized for BSA purposes in those states where such practitioners can perform physical examinations in their legally prescribed scope of practice.

MEDICAL ALERT: It is essential that the jamboree medical personnel be aware of participants who have certain physical conditions that may require special consideration. Before February 1, 2005, any person with the following health conditions: cardiac history, high blood pressure, sleep apnea, diabetes mellitus (with insulin or oral medication), obesity, asthma, sickle-cell anemia, hemophilia, severe blood dyscrasia, HIV infection, epileptic seizures, convulsions, physical disability, or psychiatric illness, must submit a request for a medical alert using the form below signed by a licensed health care practitioner to:

Boy Scouts of America
Jamboree Medical Officer, S208
1325 West Walnut Hill Lane
P.O. Box 152079
Irving, TX 75015-2079

If a Medical Alert Is Required, Please Complete the Following:

1. Fill in all blanks.
2. State the patient's health condition—the reason for a medical alert request (outlined in section VII).
3. Note prescribed medication for condition(s). (See section IV.)
4. Make a brief statement on patient's behalf for participation.
5. Sign the form and date it.
6. Photocopy and mail the **photocopy** to:

   Jamboree Medical Officer, S208
   Boy Scouts of America
   1325 West Walnut Hill Lane
   P.O. Box 152079
   Irving, TX 75015-2079

   BEFORE February 1, 2005, for final approval.

ACCESSIBILITY FOR PEOPLE WITH DISABILITIES

Limited transportation is available for show events for severely handicapped wheelchair-confined Scouts. In general, everyone must be able to walk long distances or not participate in the show events. It will be very hot and humid in Virginia at this time of the year. You must be in good physical condition to safely participate in the jamboree.

1. Patient's name (please print) _____
2. Comments about patient's condition (reason for medical alert request) _____
3. Comments about patient's need for full or limited participation _____

Physician's name (please print) _____ Phone (_____) _____

Address _____

City _____ State _____ Zip code _____

Signature of licensed health care practitioner* _____ Date _____

License No. _____ State _____ Expiration date _____

Review for Jamboree Activity

Date	Agency and activity	By	OK	Physician recheck needed	Results of recheck	Initial

Interval record: