PERSONAL HEALTH AND MEDICAL RECORD
CLASS 1 & CLASS 2 PHYSICAL FORM (WLACC-001)

Note: PARENT OR GUARDIAN SIGNATURE IS REQUIRED FOUR (4) TIMES ON THIS FORM.

The Western Los Angeles County Council, Boy Scouts of America requires that all youth campers participating in a camping experience over 72 consecutive hours (3 days and nights) must have a medical evaluation carried out by a physician licensed to practice medicine **within 36 months** prior to the camping experience. **The written medical evaluation by a physician should be completed on page 4 of this form.** An existing completed Class 2 medical evaluation form may be used in its place provided that it was completed within the 36-month period. (Please staple your existing form to page 4.)

In addition, a recent Health History/Medical Summary (pages 2 and 3) must be completed **within the six months** prior to the camping experience.

PARENTAL FIREARMS PERMISSION AND RELEASE

California State Law prohibits any person from furnishing, loaning or otherwise providing a minor any firearm or live ammunition without the express permission of their parent or guardian. Your son will not be allowed on the shooting range without the following signed release. If you do not wish your son to participate in shooting activities please write "NO PERMISSION".

MINOR'S NAME (Please print)_____

I (Please print)_____ The Parent _____ Legal Guardian _____ of the above named minor do hereby give permission as required by California Penal Code Sections 12552, 12070, 12072 and 12078, et. seq. to the Boy Scouts of America, Western Los Angeles County Council, and to instructors certified by the Western Los Angeles County Council meeting the requirements for instructors established by the Boy Scouts of America (National), to furnish a firearm, BB Gun, Air Rifle, Pellet Gun, or 002 Gun, and Ammunition to said minor for the purpose of instructing him in the safe handling of firearms, safe shooting and marksmanship.

I do further agree to indemnify and save harmless the Boy Scouts of America, Western Los Angeles County Council and all officers, members, employees, and volunteers thereof, from all suits or actions brought for, or on account of, any injuries or damages received or sustained by any person or persons by or from the consequences of any negligence or any act or omission of the above named minor occurring during the course of said instruction.

Signed: _____ Parent _____ Legal Guardian _____

Print full name: _____ Date _____

NOTE: This form is for all youth attending Resident camp at Western Los Angeles County Council Camps. When your son leaves for scout camp be sure all of this four page form goes with him. If you have a valid medical form (less than 3 years old) signed by a physician, attach it to this form. Also fill out pages 1,2 and 3 of this form. Adults should complete BSA Class 3 form # 34412 which requires an annual examination for adults over 40 years of age. *It is the responsibility of the unit leader to bring the unit's medical forms home from summer camp. At the end of the season any medical forms remaining at Camp Whitsett and Camp Emerald Bay are not kept on file.*

1. Has the participant had a medical (physical examination) within the 36 months before the camping experience?
   [ ] YES Attach a copy of the medical evaluation to this form and proceed to question 2.
   [ ] NO Complete page 3, and then schedule a physical examination with a physician licensed to practice medicine. The doctor should complete the medical evaluation on Page 4. This completed form should accompany the participant to camp. Proceed to question 2.

2. Has the participant had a tetanus shot in the last 10 years?
   [ ] YES Indicate the date of the last immunization on Page 3 and proceed to question 3.
   [ ] NO Schedule an appointment with a physician to receive a tetanus inoculation (or booster) at least 2 weeks before attending camp. Be sure to indicate the date of the tetanus shot on Page 3. Proceed to question 3.

3. Has the participant been immunized against polio?
   [ ] YES Indicate the date of the immunization on Page 3 and proceed to question 4.
   [ ] NO Polio immunization is not required for your child to attend camp but we strongly recommend that you consider this series for his protection. Talk this over with your family physician. Proceed to question 4.

4. Is the participant currently being treated by a physician?
   [ ] YES Please provide a statement from your physician indicating what current treatment is being given. This may be in the form of a letter or use Page 4 of this form. Proceed to question 5.
   [ ] NO Proceed to question 5.

5. Is the participant taking prescribed medication regularly?
   [ ] YES Please provide a statement from your physician indicating present prescribed medication, including how and when it should be administered while in camp. Proceed to question 6.
   [ ] NO Proceed to question 6.

6. Is the participant on a medically prescribed meal plan?
   [ ] YES Please provide a copy of your child's medically prescribed diet to assist our commissary in preparing meals to meet his needs. This should be sent to the council office three weeks prior to arrival with a note indicating name, troop number, and week in camp. Proceed to question 7.
   [ ] NO Proceed to question 7.

7. Have you been told by a physician that the participant should not participate in strenuous activities?
   [ ] YES Please indicate on Page 3 what specific limitations should be imposed on activities in camp. Proceed to question 8.
   [ ] NO Proceed to question 8.

8. Has the participant lost consciousness during physical activity or had a concussion due to a head injury?
   [ ] YES Please provide a current statement from a physician licensed to practice medicine on the nature and extent of current symptoms. This may be a letter, or use Page 4 of this form. Proceed to question 9.
   [ ] NO Proceed to question 9.

9. Has the participant had an illness or injury within the last 6 months that limited activity for longer than one week?
   [ ] YES Schedule a visit with a physician for an updated medical evaluation. Fill out the lines below and proceed to the next page.
   [ ] NO Fill out the lines below and proceed to the next page.

The answers to these questions are correct to the best of my knowledge regarding the health of my son:

Signed: _____ Parent _____ Legal Guardian _____

Print full name: _____ Date _____

CLASS 1 PERSONAL HEALTH AND MEDICAL HISTORY

(To be filled out annually by parent or guardian. Please use ink.)

IDENTIFICATION

Name_____ Date of birth_____ Age_____ Sex_____

Name of parent or guardian_____ Telephone_____

Home address_____ City_____ State_____ Zip_____

Business address_____ City_____ State_____ Zip_____

If person named above is not available in the event of an emergency, notify

Name_____ Relationship_____ Telephone_____

Name_____ Relationship_____ Telephone_____

Name of personal physician_____ Telephone_____

Personal health/accident insurance carrier_____ Policy No._____

Check all items that apply, **past or present,** to your health history. Explain any "Yes" answers.

ALLERGIES: Food, medicines, insects, plants Yes ☐ No ☐ Explain:_____

GENERAL INFORMATION:	Yes	No		Yes	No		Yes	No
ADHD (Attention-Deficit Hyperactivity Disorder	☐	☐	Convulsions/seizures	☐	☐	Hemophilia	☐	☐
Asthma	☐	☐	Diabetes	☐	☐	High blood pressure	☐	☐
Cancer/leukemia	☐	☐	Heart trouble	☐	☐	Kidney disease	☐	☐

Explain: _____

Please list ALL medications taken in the 30 days **prior** to arrival at the Scouting activity where this form is to be used:

_____

List any medications to be taken at camp: _____

List any physical or behavioral conditions that may affect or limit full participation in swimming, backpacking, hiking long distances, or playing strenuous physical games: _____

List equipment needed such as wheelchair, braces, glasses, contact lenses, etc.: _____

Immunizations: (Give date of last inoculation.)

Tetanus toxoid_____ Measles_____ Polio_____

Diphtheria_____ Mumps_____ _____

Pertussis_____ Rubella_____ _____

Western Los Angeles County Council Summer Camp programs may include some or all of the following activities: horseback riding, archery, swimming, boating, sailing, hiking, mountain biking, crafts, use of knife and ax, rock climbing, rappelling, team sports, and other activities. Your signature below will grant consent for the above named youth to participate in any of the above activities at camp. Please check one of the options and state any limitations:

[ ] Consent to full program [ ] Consent to program with the following limitations/exclusions:

_____

Signature of parent/guardian _____ Date _____

In case of emergency, I understand every effort will be made to contact me (if participant is an adult, my spouse or next of kin). In the event I cannot be reached, I hereby give my permission to the licensed health-care practitioner selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child (or for me, if participant is an adult).

Date_____ Signature of parent/guardian or adult_____

Western Los Angeles County Council **Boy Scouts of America**

CLASS 2 MEDICAL EVALUATION

(Read additional requirements outlined on front of form.)

Name_____ Age_____

NOTE TO LICENSED HEALTH-CARE PRACTITIONERS*: The person being evaluated will be attending one or more weeks of camp that may include sleeping on the ground and participating in strenuous activities such as hiking, boating, and vigorous group games. Please review the health history with the participant for any interim changes. **Explain any "abnormal" evaluations.**

PHYSICAL EXAMINATION (To be filled out by a licensed health-care practitioner*)

Height_____ Weight_____ BP_____/_____ Pulse_____

VISION: Normal_____ Glasses_____ Contacts_____

HEARING: Normal_____ Abnormal_____ Explain_____

Checkbox:	N	Abn		N	Abn		N	Abn
Growth development	☐	☐	Teeth	☐	☐	Genitalia	☐	☐
Skin	☐	☐	Cardiopulmonary system	☐	☐	Musculoskeletal	☐	☐
HEENT	☐	☐	Hernia	☐	☐	Neurobehavioral	☐	☐

Explain: _____

Limitations

Activity restrictions_____

Diet restrictions_____

Signature_____ Date_____
Licensed health-carepractitioner*

Address_____ Phone_____

City, State, Zip_____

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

INTERVAL RECORD	SCREENING EXAMINATION	
Date, Time, Place, Etc.	(Findings, diagnoses, treatment, instructions, disposition, etc.)	By

NAME_____ TROOP_____ CAMPSITE_____

PHOTOCOPING THIS FORM IS PERMITTED.