Checklist with Instructions-- 2017 NYLT Medical Packet

Submission deadline: May 1, 2017* Due to increased requirements by the State of Colorado, please read the instructions for Part B signatures carefully. Mail hard copies to the registrar for your session. Do not send to council office please

****** See special submission instructions for Parts B and C***

This packet contains all the current, required forms. Please **do not substitute** any other forms. Please read the following information carefully. The health and safety of our youth is always our first priority. Incomplete or inaccurate information may place the youth and staff at risk at camp or in an emergency or delay appropriate treatment. It is required that forms be submitted early to insure that the medical staff has time to review , evaluate and prepare for the medical needs of every Scout in advance.

Part A:

____Read the "Informed consent, release, and authorization" --fill in bullet or list restrictions.

____**Parent and participant signatures please**.

____Complete -Adult authorized to transport youth. Someone must be listed even if it is yourself. Include phone numbers.

____Complete- Adults NOT authorized to transport youth- list name(s) or Mark N/A

Part B: **DO NOT** leave any lines or boxes blank.

____ Provide **two** (2) emergency contacts with phone numbers that will be local and available during the week of camp.

Not 2 persons living in the same household such as parents living together. Please provide an alternate.

____ Include a clear photo copy of BOTH sides of your **health insurance card**

____ Complete health history with explanations for "yes" answers.Check all 4 allergy boxes yes or no. Please contact the registrar if your Scout has any food or other serious allergies or medical conditions that may require advance medical or food preparation.

____ Fill in NO MEDS bullet if appropriate. Physician signature required even with NO meds listed.

____ Clearly list all medications, include full name, dosage, frequency and when to dispense, (ie: AM/PM, with/without food) Meds are normally dispensed just before or after breakfast and in the evening after dinner. *Please print clearly*. Safety is most important, unclear or unreadable information makes proper dispensing of meds difficult. **Two(2) Epi-Pens and Inhalers required**.

____ Choose yes or no authorization to administer non-prescription medications.

____ **Physician signature is required on Part B** with or without medications listed.

*****NOTE**: Please submit an unsigned Part B by the deadline if your physician visit is delayed due to insurance restrictions. Submit a second copy of Part B with signature when sending Part C.

_____ Immunizations- check appropriate box- complete dates- Tetanus must be current (less then 10 years)

Part C: Please plan ahead, schedule appointments early to complete this form on time. Please review the form and be sure the physician completes every area and check box.

_____**A Physician must sign and date both Part C and Part B**

*****NOTE:** The staff understands that insurance limitations may delay the completion of Part C , the physician examination and signed Part B. Please contact the registrar before the deadline for approval of delayed submission of **signed Part B and Part C only**.

All remaining forms must be submitted by the deadline.

Colorado Addendum-Parent Authorization Form. Do not substitute any other form.

_____ Complete name, date of birth, and guardian information in top section**.**

_____ Fill in **ALL** immunization dates or attach a printed record of immunization to the top section- mark "see attached". Tetanus must be up to date (less that 10 years).

_____ If your scout is all or partially IMMUNIZATION EXEMPT for any reason please fill out the BSA "Immunization Exempt Request" form and it must be included with your Medical Form Packet.

http://www.denverboyscouts.org/openrosters/DocDownload.aspx?id=169328

Complete **ALL 4 sections** in the Parent Authorization lower portion completely

_____ 1.Parent/ Guardian information- do not leave any lines blank- both parents required.

_____ 2.Individual authorization for travel. Mark N/A if does not apply

_____ **3.Signature required** in authorization for above named person(scout) to participate in all trips and excursions away from the campsite.

_____ **4. Signature required.** List restrictions of activities or mark N/A

Over the Counter medication permission form

_____ Please mark "yes" OR "no" for each item listed. Indicated any allergy information.

_____ **Parent/Guardian Signature required**

Remember: we do not need originals, please send CLEAR copies. We recommend you keep copies for yourself of your medical packet for your future use. All medical forms provided to the NYLT program will not be returned.

Part A: Informed Consent, Release Agreement, and Authorization

A

Full name: _____

DOB: _____

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.

! **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, Philmont Training Center, Northern Tier, Florida 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)

Second parent/guardian signature for youth: _____ Date: _____

(If required; for example, California)

Complete this section for youth participants only:

Adults Authorized to Take to and From Events:

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

Name: _____

Telephone: _____

Name: _____

Telephone: _____

Adults NOT Authorized to Take Youth To and From Events:

Name: _____

Telephone: _____

Name: _____

Telephone: _____

Part B: General Information/Health History

B

Full name: _____

DOB: _____

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

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

Address: _____

City: _____ State: _____ ZIP code: _____ Telephone: _____

Unit leader: _____ Mobile phone: _____

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**:
☐	☐	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	**Last attack date**:
☐	☐	Lung/respiratory disease	
☐	☐	COPD	
☐	☐	Ear/eyes/nose/sinus problems	
☐	☐	Muscular/skeletal condition/muscle or bone issues	
☐	☐	Head injury/concussion	
☐	☐	Altitude sickness	
☐	☐	Psychiatric/psychological or emotional difficulties	
☐	☐	Behavioral/neurological disorders	
☐	☐	Blood disorders/sickle cell disease	
☐	☐	Fainting spells and dizziness	
☐	☐	Kidney disease	
☐	☐	Seizures	**Last seizure date**:
☐	☐	Abdominal/stomach/digestive problems	
☐	☐	Thyroid disease	
☐	☐	Excessive fatigue	
☐	☐	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 B: General Information/Health History

B

Full name: _____

DOB: _____

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

Allergies/Medications

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

Yes	No	Allergies or Reactions	Explain
☐	☐	Medication	
☐	☐	Food	
☐	☐	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 INDICATE 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 by the BSA. 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

C

This part must be completed by certified and licensed physicians (MD, DO), nurse practitioners, or physician assistants.

Full name: _____

DOB: _____

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

! **You are being asked to certify that this individual has no contraindication for participation inside 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.** !

Examiner: Please fill in the following information:

	Yes	No	Explain
Medical restrictions to participate	☐	☐	

Yes	No	Allergies or Reactions	Explain	Yes	No	Allergies or Reactions	Explain
☐	☐	Medication		☐	☐	Plants	
☐	☐	Food		☐	☐	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	☐	☐	
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.
☐	☐	Does not have uncontrolled heart disease, asthma, 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 less than 18 years of age and planning to scuba dive, does not have diabetes, asthma, or seizures.
☐	☐	**For high-adventure participants, I have reviewed with them the important supplemental risk advisory provided.**

Examiner's Signature: _____ **Date:** _____

Provider 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

COLORADO LAW REQUIRES THAT THIS FORM BE COMPLETED FOR EACH SCOUT ATTENDING A COLORADO SCOUT CAMP

Name_____ **Date of Birth**_____

Parent/Guardian_____ **Dates of the Camp Session**_____

COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT CERTIFICATE OF IMMUNIZATION

Vaccine		(Enter the month, day and year each immunization was given.)					
Hep B	Hepatitis B						
DTaP	Diphtheria, Tetanus, Pertussis (pediatric)						
DT	Diphtheria, Tetanus (pediatric)						
Tdap	Tetanus, Diphtheria, Pertussis						
Td	Tetanus, Diphtheria						
Hib	*Haemophilus influenzae* type b						
IPV/OPV	Polio						
PCV	Pneumococcal Conjugate						
MMR	Measles, Mumps, Rubella						
Varicella	Chickenpox			Healthcare Provider Documentation Date_____		Lab Verification Date_____	

STATEMENT OF EXEMPTION TO IMMUNIZATION LAW

IN THE EVENT OF AN OUTBREAK, EXEMPTED PERSONS MAY BE SUBJECT TO EXCLUSION FROM CAMP AND TO QUARANTINE.

MEDICAL EXEMPTION: The physical condition of the above named person is such that immunization would endanger life or health or is medically contraindicated due to other medical conditions.

Signed _____ Date _____
Physician (Medico)

Medical exemption *to the following vaccine(s):*
La exención por razones médicas *aplica a la(s) siguiente(s) vacuna(s):*

☐ HepB ☐ DTaP ☐ Tdap ☐ Hib ☐ IPV ☐ PCV ☐ MMR ☐ VAR

RELIGIOUS EXEMPTION: Parent or guardian of the above named person or the person himself/herself is an adherent to a religious belief opposed to immunizations.

Signed _____ Date _____
Parent, guardian, emancipated Scout/counseling minor

Religious exemption *to the following vaccine(s):*
Exención por motives religiosos *de la(s) siguiente(s) vacuna(s):*

☐ HepB ☐ DTaP ☐ Tdap ☐ Hib ☐ IPV ☐ PCV ☐ MMR ☐ VAR

PERSONAL EXEMPTION: Parent or guardian of the above named person or the person himself/herself is an adherent to a personal belief opposed to immunizations.

Signed _____ Date _____
Parent, guardian, emancipated Scout/counseling minor

Personal exemption *to the following vaccine(s):*
Exención por creencias personales *de la(s) siguiente(s) vacuna(s):*

☐ HepB ☐ DTaP ☐ Tdap ☐ Hib ☐ IPV ☐ PCV ☐ MMR ☐ VAR

PARENT/GUARDIAN AUTHORIZATIONS

Parent/Guardian Name_____
Parent/Guardian Address_____
Parent/Guardian Telephone Day_____
Eve_____ Cell_____
Place of Employment_____
Address_____
Phone #_____

Parent/Guardian Name_____
Parent/Guardian Address_____
Parent/Guardian Telephone Day_____
Eve_____ Cell_____
Place of Employment_____
Address_____
Phone #_____

Individual authorized to take the Scout from camp if different from the parent or guardian:
Name_____ Address_____ City_____ ST____ Zip_____
Phone # Day_____ Eve_____ Cell_____

I hereby authorize the above named person to participate in all special trips or excursions in which the Scout may be walking or riding away from the campsite.
Parent/Guardian/Custodial Adult_____ Date_____

The above named person is restricted from the activities listed below:
_____ _____
_____ _____
_____ _____
_____ _____

Parent/Guardian/Custodial Adult_____ Date_____

Copy Front and Back side of **Medical Insurance Card** onto this single sheet

This card is for (name): _____

Front of Card

Back of Card

Scout Name:_____ **Date of Birth:**_____

Allergic to:_____

Over-the Counter Medication Dispensation Permission Form

Purpose: The Medical Staff has limited supplies of the medications listed below, if you know your scout will possibly need one of these, please send it (preferably new) with them, in the original container and labeled with their name.

YOU ARE GIVING PERMISSION FOR THE FOLLOWING MEDICATIONS TO BE GIVEN IF INDICATED, IF NEEDED. MEDICATIONS WILL BE ADMINISTERED IN ACCORDANCE WITH THE DOSAGES ON THE OTC MEDICAL CONTAINER

YES	NO	Medication
◯	◯	Acetaminophen (Tylenol®)
◯	◯	Ibuprofen (Advil®/Motrin®)
◯	◯	Diphenhydramine (Benadryl®)
◯	◯	Loratadine (Claritin®)
◯	◯	Cetirizine HCL (Zyrtec®)
◯	◯	Cough Drops or Throat Lozenges
◯	◯	1% Hydrocortisone Cream
◯	◯	Antibiotic topical ointment (Bacitracin®)
◯	◯	Sunscreen Lotion
◯	◯	Sunburn Gel (Solarcaine®, Aloe Vera, Lip Balm)
◯	◯	Skin Itch Treatment (Calamine Lotion)
◯	◯	Calcium Carbonate (Tums®)
◯	◯	Magnesium Sulfate (Epsom Salts®)
◯	◯	Midol® (Females Only)

WAIVER: In consideration of the benefits to be derived, in view of the fact that participation in Scouting Activities is voluntary, and having full confidence that reasonable precautions will be taken to ensure my Scout's safety and well-being, I agree to their participation in Scouting Activities and waive all claims against the leaders of NYLT, BSA Scouting Activity, and/or its sponsor. I have provided the Denver Area Council with current and accurate medical information about my Scout.

Signature (Parent):_____ Date: _____

Print Name (Parent):_____

Emergency Contact Phone Number: _____