PIEDMONT COUNCIL - BOY SCOUTS OF AMERICA
10 HIGHLAND WAY - PIEDMONT, CA 94611 - TEL (510) 547-4493 - FAX (510) 547-4400

AUTHORIZATION TO TREAT A MINOR

I (We), the undersigned parent(s) of _____, a minor, do hereby authorize the Officers or Representatives of the PIEDMONT COUNCIL, BOY SCOUTS OF AMERICA, as agent(s) for the undersigned to consent to X-Ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is being rendered under the general or special supervision of any physician and surgeon licensed under the provisions of Medical Practice Act on the medical staff of _____* Hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said Hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable.

This authorization is given pursuant to the provision of SECTION 25.8 of the CIVIL CODE OF CALIFORNIA.

This authorization shall remain effective until _____, 20_____, unless sooner revoked In writing delivered to said agent(s).

Dated _____, 20_____ Signed _____(father)

Witnessed by: _____ _____ (mother)

Witnessed by: _____ _____(legal Guardian)

(one or both parents, or legal guardian may sign)

**Name of nearest accredited hospital will be filled in by agent(s) at time used*

Note: No treatment will be authorized by the Representative of the Piedmont Council, Boy Scouts of America until every effort has been made to contact the parent(s) or legal guardian. Be sure the Council Office, Camp leaders and Unit Leaders are notified of any change of emergency telephone and/or address.

IN CASE OF EMERGENCY, NOTIFY:

Name _____ Relationship: Parent ____ Guardian ____ Other ____

Address: _____ City _____ Zip _____

Phone: ( ) _____ Family Insurance Company _____

Policy number # _____

Doctor _____ Phone ( ) _____

10/29/2003

PERSONAL HEALTH AND MEDICAL RECORD FORM—Class 3

BOY SCOUTS OF AMERICA

All Class 3 activities require a health examination within the past 12 months by a licensed health-care practitioner.* This includes youth and adult members participating in high-adventure activities, athletic competition, and world jamborees. Annually, this form is to be used by adults 40 years of age or older for all activities requiring a physical examination and applies to **all** Wood Badge participants/staff regardless of age.

PLEASE TYPE OR PRINT.

NAME _____ UNIT _____

NOTE: Keep original form for your personal record. Make reproductions for agency use. Be sure information and signatures are legible on reproduced copies. This upper section may be reproduced and carried with you for emergency identification and care.

I. IDENTIFICATION

Age____ Sex____

Name _____ (Last name, First name, Initial)

Date of Birth* (Mo. Day Year)

Address _____

City & State _____ Zip _____

Health/Accident insurance _____ Policy no. _____

IN AN EMERGENCY NOTIFY:

Name _____ Relationship _____

Address _____ Home phone

City & State _____ Business phone

Personal Physician _____ Phone

II. EMERGENCY MEDICAL INFORMATION

Has or is subject to (check and give details):

- ☐ Allergy to a medicine, food†, plant, animal, or insect toxin
- ☐ Any condition that may require special care, medication, or diet
- ☐ ADHD (Attention Deficit Hyperactive Disorder)
- ☐ Asthma ☐ Convulsions ☐ Heart trouble ☐ Contact lenses
- ☐ Diabetes† ☐ Fainting spells ☐ Bleeding disorders ☐ Dentures

EXPLAIN _____

III. PARENTAL STATEMENT

Has it ever been necessary to restrict applicant's activities for medical reasons? ☐ No ☐ Yes Does applicant take medicine regularly or have special care? ☐ No ☐ Yes If yes, explain.

_____

To the best of my knowledge, the information in sections I, II, III, IV, and VI is accurate and complete. I request a 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 BSA programs, subject to limitations noted herein. In the event of illness or accident in the course of such activity, I request that measures be instituted without delay as judgment of medical personnel dictates.

Parent or guardian _____
(Must sign if applicant is 18 or younger)

Applicant's signature _____

Date signed _____

Updated _____ Signed _____
Parent or guardian

Updated _____ Signed _____
Parent or guardian

IV. IMMUNIZATIONS

If disease, put "D" and year.

	Last year given
Tetanus	
Diphtheria	
Pertussis	
Measles	
Mumps	
Rubella	
Polio	
Chicken Pox	

Religious preference

V. LICENSED HEALTH-CARE PRACTITIONER'S EVALUATION AND ADVICE

Approved for participation in:

- ☐ Hiking and camping
- ☐ Water activities
- ☐ Competitive sports
- ☐ All activities

Specify exceptions _____

Recommendations (explain any restrictions OR limitations): _____

_____

_____

Date _____

Signed _____
*Licensed health-care practitioner

*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.

VI. MEDICAL HISTORY

Parent (or applicant if 18 or older): Fill in sections I, II, III, IV, and VI *before seeing a licensed health-care practitioner.* Check immunizations 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, illnesses, surgery, or significant changes in condition of health of applicant since last complete examination.

- Date of most recent complete physical examination (month and year) _____ 20____
- Are you aware of any current health problems? ☐ No ☐ Yes
- Now under medical care or taking medicines? ☐ No ☐ Yes
- Has there been any surgery, injury, illness, allergy, or change in health status since last complete physical examination? ☐ No ☐ Yes

Give dates and full details below for any "yes" answers.

IS THERE DISEASE OF (OR PAST OR PRESENT HISTORY OF):	No	Yes	Year	Details/Medicines
Serious illness	☐	☐		
Serious injury	☐	☐		
Deformity	☐	☐		
Surgery	☐	☐		
Skin, glands	☐	☐		
Ears, eyes	☐	☐		
Nose, sinus	☐	☐		
Teeth, tonsils	☐	☐		
Dentures	☐	☐		
Bridge	☐	☐		
Chest, lungs	☐	☐		
Heart	☐	☐		
Murmur	☐	☐		
Rheumatic fever	☐	☐		
Stomach, bowels	☐	☐		
Appendicitis	☐	☐		
Kidneys or urine	☐	☐		
Albumin	☐	☐		
Sugar	☐	☐		
Infection	☐	☐		
Bed-wetting	☐	☐		
Menstrual problems	☐	☐		
Hernia (rupture)	☐	☐		
Back, limbs, joints	☐	☐		
Sleepwalking	☐	☐		
Nervous condition	☐	☐		
Other (explain)	☐	☐		

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

_____

_____

_____

VII. 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: athletic competition, adventure challenge or wilderness expedition (afoot or afloat) that may include high altitude, extreme weather conditions, cold water, exposure, fatigue, and/or remote conditions where readily available medical care cannot be assured.

- Please insist applicant furnish complete medical history (VI) before exam.
- Review immunizations; for youth (18 or younger) tetanus and diphtheria toxoids, measles, mumps, and rubella vaccines, and trivalent oral polio vaccine are required; youths and adults must have had tetanus booster within 10 years. A measles booster is recommended at age 12.
- After completing section VII, summarize any restrictions and/or recommendations in sections II and V, above, and sign.

Date _____ VISION: Normal _____ HEARING: Normal _____

Ht. _____ Wt. _____ Glasses _____ Abnormal _____

B.P. _____ / _____ Pulse _____ Contacts _____

Check box if normal; circle 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
- ☐ Skeletomuscular
- ☐ Neuropsychiatric
- ☐ Other (specify)

COMMENTS _____

_____

_____

_____

_____

FOR THOSE ATTENDING PHILMONT OR NATIONAL HIGH-ADVENTURE BASES:

* The minimum age for all participants is 13 by January 1 of the year of participation, or have completed the seventh grade. No exceptions.

† Trail food is by necessity a high-carbohydrate, high-calorie diet. It is high in wheat, milk products, sugar, corn syrup, and artificial coloring/flavoring. Dinner meals contain meat. If these food products cause a problem in your diet, you need to bring appropriate substitutions with you and so advise base personnel.

Note: Licensed health-care practitioners representing high-adventure bases reserve the right to deny access to the trails or other program activity on the basis of a medical evaluation performed at the base after arrival.

REVIEW FOR CAMP OR SPECIAL ACTIVITY

DATE	AGENCY AND ACTIVITY	BY	"OK"	PHYSICIAN RECHECK NEEDED	RESULTS OF RECHECK	INITIAL

INTERVAL RECORD (CAMP, CAMPOREE, TOURNAMENT, TRAVEL, ETC.)

DATE, TIME, PLACE, ETC.	FINDINGS, DIAGNOSES, TREATMENT, INSTRUCTIONS, DISPOSITION, ETC.	BY:

#34412B