

Youth Medical Forms

The following documents will need to be submitted to Camp Alexander prior to arrival. Each participant will receive an invite from healthforms.io to the email address provided in the registration. You will use this to upload your forms. The "Group Leader" from each unit will receive an invite to be a manager of your unit, which will allow you to view an upload forms as needed.

HIGHLIGHTED ITEMS WILL REQUIRE DR. SIGNATURE - BE SURE TO TAKE THEM TO PHYSICAL APPOINTMENT.

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. **Colorado Immunization Form** (if you have been provided with a printout from your local medical facility, please write in all immunizations on the Colorado Form, get signature/ stamp, and submit your local form as well)
3. Copy of Health Insurance Card
4. Colorado Addendum – Additional Information/Sunscreen Permission Form
5. **Permission for Medication Administration/Medication Log** – *only if scout is taking medications & A SEPARATE FORM IS NEEDED EACH medication scout is taking. Must be signed by Health Care Provider.*
6. **Colorado Addendum** – Contract to Carry (emergency medication) – *only if scout needs emergency medication that must be carried with them, ALL SIGNATURES REQUIRED.*

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: _____



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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 ☐ NODO 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
		Medication	
		Food	

Yes	No	Allergies or Reactions	Explain
		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 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



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COLORADO CERTIFICATE OF IMMUNIZATION

cdphe.colorado.gov/immunization



COLORADO

Department of Public
Health & Environment

This form is to be completed by a health care provider (physician [MD, DO], advanced practice nurse [APN] or delegated physician's assistant [PA]) or school health authority. School-required immunizations follow the Advisory Committee on Immunization Practices (ACIP) schedule. If the student provides an immunization record in any other format apart from this Certificate or an Approved Alternate Certificate (details found at cdphe.colorado.gov/immunization/forms), the school health authority must transcribe the record onto this form. Note: Final doses of DTaP, IPV, MMR and Varicella are required prior to kindergarten entry. Tdap is required at sixth grade entry.

Student Name: _____

Date of birth: _____

Parent/guardian:(if student is under 18 years of age and not emancipated) _____

Required Vaccines

Immunization date(s) MM/DD/YY

Titer Date*
MM/DD/YY

HepB Hepatitis B										
DTaP Diphtheria, Tetanus, Pertussis (pediatric)†										
Tdap Tetanus, Diphtheria, Pertussis†										
Td Tetanus, Diphtheria										
Hib Haemophilus influenzae type b										
IPV/OPV Polio										
PCV Pneumococcal Conjugate										
MMR Measles, Mumps, Rubella ‡										
Measles										
Mumps										
Rubella										
Varicella Chickenpox										
Varicella - date of disease										
Varicella - positive screen date										

*The shaded area under "Titer Date" indicates that a titer is not acceptable proof of immunity for this vaccine.

In several instances, laboratory confirmation of positive titers are an acceptable alternative to written documentation of vaccination. A positive laboratory titer report must be provided to the school to document immunity. More information on titers can be found within the Colorado Board of Health rule 6 CCR 1009-2.

† For DTaP and Tdap, both the diphtheria and tetanus titers must be positive. A titer is never acceptable to demonstrate immunity to pertussis.

‡ Laboratory confirmation of positive titers are an acceptable alternative to the MMR vaccine only when titers for all three components (measles, mumps, and rubella) are positive.

Recommended Vaccines

Immunization date(s) MM/DD/YY

HPV Human Papillomavirus										
RV Rotavirus										
MCV4 Meningococcal										
MenB Meningococcal										
HepA Hepatitis A										
Flu Influenza										
COVID-19										
Other										

Health care provider printed name/signature: _____ / _____

Date: _____

Student is current on required immunizations for age (circle one): OR Yes No

Immunization record transcribed/reviewed by school health authority:

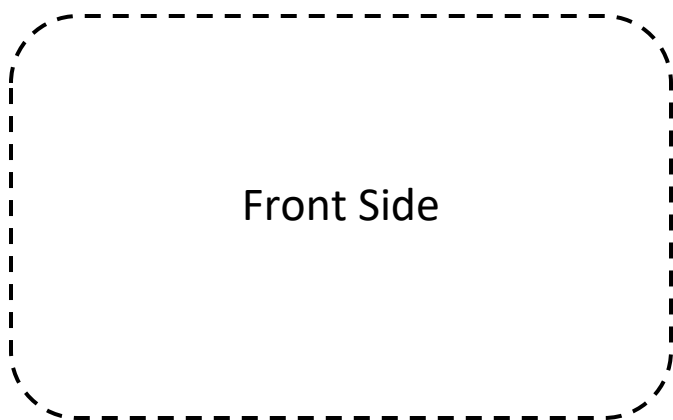
School health authority signature or stamp: _____

Date: _____

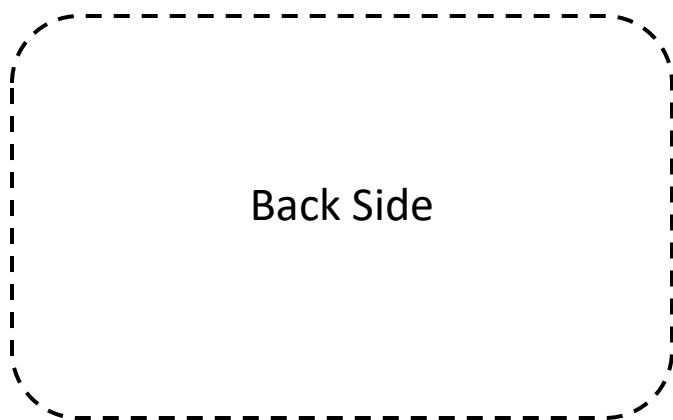
(Optional) I authorize my/my student's school to share my/my student's immunization records with state/local public health agencies and the Colorado Immunization Information System, the state's secure, confidential immunization registry.

Parent/Guardian/Student (emancipated or over 18 yrs old) signature: _____ Date: _____

Copy of Health Insurance Card

A dashed rectangular box with rounded corners, intended for a copy of the front side of a health insurance card.

Front Side

A dashed rectangular box with rounded corners, intended for a copy of the back side of a health insurance card.

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.

COLORADO SUMMER CAMP ADDITIONAL REQUIRED INFORMATION

Colorado Addendum – Additional Information

ALL INFORMATION ON THIS FORM MUST BE FILLED OUT ENTIRELY PER THE STATE OF COLORADO

Participant's Name: _____ Campsite: _____
Date of Birth: _____ Camp Session: _____ to _____
Unit Type: _____ Unit Number: _____

[CCR 7.711.41.A.2] – Legal Parent/ Guardian Contact Information

	Parent/Guardian #1	Parent/Guardian #2
Name:		
Relationship:		
Home Address: (Street, City, St, Zip)		
Work Address: (Street, City, St, Zip)		
Email:		
Phone Number: (Primary)		
Phone Number: (Secondary)		

[CCR 7.711.411.A.4] – Authorized Person(s) Allowed to Take Child from Camp

Please indicate the individual(s) who are authorized to take your child from camp if a parent/ guardian is unavailable. Consider listing the **Adult Leader doing transportation to and from camp** & another emergency contact.

(Attached additional sheets as needed.)

	Individual #1	Individual #2
Name:		
Relationship:		
Home Address: (Street, City, St, Zip)		
Email:		
Phone Number: (Primary)		
Phone Number: (Secondary)		

I hereby authorize my child to participate in all excursions, off-camp activities & special trips in which the Scout may walk or ride away from the campsite. ☐ Yes ☐ No

Parent/ Guardian Name: _____ Signature: _____ Date: _____

[CCR 7.711.31. 0] – Sunscreen Authorization

I authorize my child to use & wear sunscreen at camp. I also authorize BSA Camp Staff to aid my child in the application of sunscreen if they request it. I understand that if my child needs sunscreen, they can request it at any time, and it will be SPF 30 or greater. ***I also understand that my child's name needs to be written on the sunscreen bottle they come to camp with.***

☐ Yes ☐ No, Alternative Instructions: _____

Parent/ Guardian Name: _____ Signature: _____ Date: _____

This information is required by the State of Colorado Department of Human Services, Division of Early Learning and Care, Office of Child Care Licensing. This form is required for all BSA Summer Camps in Colorado. Questions about this additional paperwork can be directed to the State of Colorado Department of Human Services, Office of Early Childhood at 303-866-5948 or cdhs_oec_communications@state.co.us.

Permission for Medication Administration for Schools, Child Care Centers and Resident Camps

The parent/guardian of _____ ask that school/child care staff give the following medication _____ at _____ to my child, according to the Health Care Provider's signed instructions on the lower part of this form.

Child's Name

Name of Medicine & Dosage

Time(s)

Prescription medications must come in a container labeled with: child's name, name of medicine, time medicine is to be given, dosage, route, date medicine is to be stopped, and licensed Health Care Provider's name. Pharmacy name and phone number must also be included on the label.

Over the counter medication must be labeled with child's name. Dosage must match the signed Health Care Provider authorization, and medicine must be packaged in original container.

The school/child care agrees to administer medication prescribed by a licensed Health Care Provider with prescriptive authority. The parent agrees to pick up expired or unused medication within one week of notification by staff. All medication(s) left at the school will be discarded according to the most current state regulatory recommendations for safe medication disposal.

By signing this document, I give permission for my child's Health Care Provider to share information about the administration of this medication with the school staff delegated to administer medication.

Parent/Legal Guardian's Name

Parent/Legal Guardian Signature

Date

Work Phone

Alternate Phone

Health Care Provider Authorization

Child's Name:		Birthdate:
Medication:	Dosage:	Route:
To be given at the following times:	Start Date:	End Date:
Special Instructions:		
Purpose of Medication:		
Side Effects to be reported:		

Signature of Health Care Provider with Prescriptive Authority

Date

Print Name of Health Care Provider

Phone & Fax Number

Signature of Child Care Health Consultant or School Nurse

Date

Log 2 Week Medication Administration

School/Child Care:					
Child's Name:		Birthdate:		Classroom:	
Medication:		Dosage:	Route:	Time to be given:	
Start Date:		End Date:		Expiration Date:	
Special Instructions:					
Health Care Provider Prescribing Medication:				Phone:	
Parent Name:		Parent Work Phone:		Parent Cell Phone:	

Time	Week of:					Week of:				
	Mon Date:	Tue Date:	Wed Date:	Thurs Date:	Fri Date:	Mon Date:	Tue Date:	Wed Date:	Thurs Date:	Fri Date:
AM:										
AM:										
PM:										
PM:										

Include time medication given and initials. If child absent, mark box with "A"; If medication not given, mark box "NG". Document reason not given in comments.

Date & Comments:	Staff Signatures	Initials

Intake and Count for All Medication

All controlled medications must be counted and verified by two medication trained staff members or by one staff member and parent (i.e. Ritalin, Dexedrine)

Date	Name of Medication and Dosage	Expiration Date	Amount Received	Parent Signature	Staff Initials

COLORADO SUMMER CAMP ADDITIONAL REQUIRED INFORMATION

Colorado Addendum – Contract to Carry

This is for Scouts (Youth - 17 & younger) who need to carry emergency medications while at summer camp.

ALL SIGNATURES ARE REQUIRED

This contract is intended for Scouts diagnosed with asthma, anaphylaxis, severe allergies, and/or other life-threatening conditions and is in effect while the Scout is at camp. Colorado Child Care Regulation 7.711.31.4.

Scout Name: _____ Date of Birth: _____

Camp: _____ Medication(s): _____

Purpose of Medication(s): _____

Scout/Child:

- I agree to keep my medication with me while at camp and use it in a responsible manner.
- I will notify Camp staff when I use my medication.
- I will notify Camp Health Staff immediately if my condition for which I am prescribed my medication presents any unusual difficulty or symptoms.
- I will not allow any other Scout to administer or use my medication.
- I understand that if I fail to comply with this contract, my privilege to carry and self-administer the medication may be withdrawn, which could result in being sent home from camp.

Scout Signature: _____ Date: _____

Parent or Guardian:

- I assure that my child will carry his/her medication as prescribed, that the medication will be appropriately labeled by a pharmacist or healthcare provider and that the medication has not expired.
- I will assure that back-up medication is provided to the Camp Health Staff for emergencies.

Parent/Guardian Signature: _____ Date: _____

Unit Leader:

- I agree to make sure the Scout will keep the medication with them at all time and make sure that it is used in a responsible manner.
- I will monitor the Scouts use of the medication and alert the Camp Health Staff if the medication is used and if the Scout's condition gets worse or do not resolve in a timely manner.
- I will monitor the medication and ensure that it will not be administered or used by another Scout.
- I have reviewed the medical condition for which the Scout is provided the medication for.

Unit Leader Signature: _____ Date: _____

Doctor or Health Care Provider:

- I assure that the child listed on this document needs the listed medications and can self-administer as needed.
- I assure that the child is aware of the proper procedure of self-administering.

Health Care Provider Signature: _____ Date: _____

Camp Health Staff:

- I assure that the child has demonstrated the proper technique for self-administering the medication.
- I assure the child knows the proper times and dosages for when to administer.
- I assure that the appropriate Camp Staff will be notified of the child's condition and that they are carrying medication.

Health Staff Signature: _____ Date: _____

This information is required by the State of Colorado Department of Human Services, Division of Early Learning and Care, Office of Child Care Licensing. Questions about this additional paperwork can be directed to the State of Colorado Department of Human Services, Office of Early Childhood at 303-866-5948 or cdhs_oec_communications@state.co.us.