

## Part A: Informed Consent, Release Agreement, and Authorization

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: \_\_\_\_\_

Name: \_\_\_\_\_

Telephone: \_\_\_\_\_

Telephone: \_\_\_\_\_

#### Adults NOT Authorized to Take Youth To and From Events:

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Telephone: \_\_\_\_\_

Telephone: \_\_\_\_\_



## Part B: General Information/Health History

**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
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<b>Last HbA1c percentage and date:</b>
<input type="checkbox"/>	<input type="checkbox"/>	Hypertension (high blood pressure)	
<input type="checkbox"/>	<input type="checkbox"/>	Adult or congenital heart disease/heart attack/chest pain (angina)/heart murmur/coronary artery disease. Any heart surgery or procedure. Explain all "yes" answers.	
<input type="checkbox"/>	<input type="checkbox"/>	Family history of heart disease or any sudden heart-related death of a family member before age 50.	
<input type="checkbox"/>	<input type="checkbox"/>	Stroke/TIA	
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<b>Last attack date:</b>
<input type="checkbox"/>	<input type="checkbox"/>	Lung/respiratory disease	
<input type="checkbox"/>	<input type="checkbox"/>	COPD	
<input type="checkbox"/>	<input type="checkbox"/>	Ear/eyes/nose/sinus problems	
<input type="checkbox"/>	<input type="checkbox"/>	Muscular/skeletal condition/muscle or bone issues	
<input type="checkbox"/>	<input type="checkbox"/>	Head injury/concussion	
<input type="checkbox"/>	<input type="checkbox"/>	Altitude sickness	
<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric/psychological or emotional difficulties	
<input type="checkbox"/>	<input type="checkbox"/>	Behavioral/neurological disorders	
<input type="checkbox"/>	<input type="checkbox"/>	Blood disorders/sickle cell disease	
<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells and dizziness	
<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	
<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<b>Last seizure date:</b>
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal/stomach/digestive problems	
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	
<input type="checkbox"/>	<input type="checkbox"/>	Excessive fatigue	
<input type="checkbox"/>	<input type="checkbox"/>	Obstructive sleep apnea/sleep disorders	<b>CPAP: Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	List all surgeries and hospitalizations	<b>Last surgery date:</b>
<input type="checkbox"/>	<input type="checkbox"/>	List any other medical conditions not covered above	



## Part B: General Information/Health History

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	Yes	No	Allergies or Reactions	Explain
<input type="checkbox"/>	<input type="checkbox"/>	Medication		<input type="checkbox"/>	<input type="checkbox"/>	Plants	
<input type="checkbox"/>	<input type="checkbox"/>	Food		<input type="checkbox"/>	<input type="checkbox"/>	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)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tetanus	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pertussis	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diphtheria	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Measles/mumps/rubella	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Polio	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Meningitis	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Influenza	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (i.e., HIB)	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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: \_\_\_\_\_



# NCAC Scout Camp Risk Advisory to Health-Care Providers, Parents, and Adult Participants

Adult

Youth

Participant Name \_\_\_\_\_

## GET FIT FOR CAMP

Scout Camp can be physically and mentally demanding, and involves strenuous activities. Parents new to Scouting may not appreciate the level of outdoor physical activity involved in summer camp. Simply a day of extensive walking around camp involving varied and often hilly terrain, swimming, canoeing, and other activities may be more strenuous activity than many adults and scouts undertake in a week. Poor health and/or lack of awareness of risk factors can lead to disabling injuries, illnesses, and even fatalities. Participants should understand potential health risks inherent in camping while being exposed to occasional severe weather conditions such as lightning, high heat & humidity (Camp is not air conditioned.); and other potential problems, including injuries from tripping and falling. Mosquitoes, ticks, bees, and poison ivy may be encountered. Goshen Scout Reservation is located in the Allegheny Mountains in Virginia. The closest hospital is in Lexington, a little more than 30 minutes away. In light of this, we suggest more than one injector for use to counteract anaphylactic shock at Goshen. Camp Snyder is located in Haymarket, VA with the nearest hospital less than 10 minutes away. Both Camps have medical facilities and personnel for routine and emergency care. **Take your physical exam seriously**, and take responsibility for your own health and safety. All participants, if you are not engaging in a weekly program of sustained physical activity, please consult your doctor and safely begin one.

## RISK FACTORS

*Participants should discuss with your health care provider your risk factors, including, but not limited to:*

**Cardiac or Cardiovascular condition** - Chest pain, myocardial infarction (heart attack), or family history of heart disease, heart surgery, including angioplasty, to treat blocked blood vessels or place stents, stroke or transient ischemic attacks.

**Hypertension** - Participants with significant hypertension should be under treatment and their condition should be under control.

**Excessive weight or smoking** - See chart on health form Part C for height and weight limits. The camp leader guides share restrictions on smoking at camp.

**Diabetes** - Bring enough medication, testing supplies, and equipment for the entire week, including batteries.

**Seizure disorder or epilepsy** - Should be well-controlled by medications. Participants with a history of seizures need to limit high-adventure activities like climbing or rappelling.

**Asthma** - Should be well controlled. Participants must carry a rescue inhaler at all times during any Scouting event.

**Sleep Apnea** - All required equipment, like a CPAP machine and batteries, must be provided by the camper.

**Allergies or Anaphylaxis** - See note above in regard to having more than one injector for camp.

**Ingrown Toenails, Recent Musculoskeletal Injuries, and Orthopedic Surgery** - Ingrown toenails should be treated within a month prior to camp. Scouts and Scouters who have had orthopedic surgery, including arthroscopic surgery, or significant musculoskeletal injuries, should have a release from their treating physician to participate.

**Psychiatric/Psychological and Emotional Difficulties** - Any condition must be well controlled without the services of a mental health practitioner. Campers are required to bring an appropriate supply of medication for the duration of camp, including travel to and from.

**Any other Risk Factors** - **The physical exertion at camp may precipitate either a heart attack or stroke in susceptible people.**

**Participants with a history of any risk factors for these should have a physician-supervised stress test. If the test results are abnormal, the individual should not participate.**

## SWIM RISK ADVISORY FOR SUMMER CAMPS

This swim classification test is very physically demanding, particularly for adults.

Participants, both youth and adults, attending a NCAC summer camp will, on first day check-in day, have the opportunity to participate in a swim ability evaluation in cool lake water at the waterfront (Goshen), or cool pool water (Snyder). We recommend spending **practice time** in a pool prior to camp as beneficial, especially for participants who do not swim regularly.

Successful completion of this evaluation, consisting of a **100-yard swim** consisting of the requirements of the BSA swim test, enables the participant to fully participate in all aquatic activities during the week. Participants who are not able to meet the swimmer requirements may be classified at a lower level, e.g., beginner or non-swimmer, which will result in more limited aquatic activities. If an adult, after consultation with your doctor, is not deemed sufficiently fit for the swim classification test, or has no interest in using the aquatic facilities, the adult can opt out of the swim test.

**Camp Medical Staff reserve the right to deny the participation of any individual on the basis of a physical examination and/or medical history. Each participant is subject to a medical recheck at Camp**

## DISCUSS WITH HEALTH-CARE PROVIDER

Showing Parts A, B, and C of the BSA Annual Health & Medical Record (AMHR), and this NCAC Scout Camp Risk Advisory to a participant's examining health-care provider informs the provider of the participant's health history, who can update it if necessary, and associated camp risk factors.

I certify I have shown Parts A, B, and C of the BSA Annual Health & Medical Record (AMHR), this Scout Camp Risk Advisory, including the swim classification test, described above, and discussed my / my child's medical risk factors with my health-care provider in connection with the BSA Annual Health & Medical Record (AMHR) and this NCAC Risk Advisory form.

\_\_\_\_\_  
Signature of Adult Participant / Parent / Guardian

\_\_\_\_\_  
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: \_\_\_\_\_

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		<input type="checkbox"/>	<input type="checkbox"/>								
Yes	No	Allergies or Reactions		Explain		Yes	No	Allergies or Reactions		Explain	
<input type="checkbox"/>	<input type="checkbox"/>	Medication				<input type="checkbox"/>	<input type="checkbox"/>	Plants			
<input type="checkbox"/>	<input type="checkbox"/>	Food				<input type="checkbox"/>	<input type="checkbox"/>	Insect bites/stings			
Height (inches): _____		Weight (lbs.): _____		BMI: _____		Blood Pressure: _____ / _____		Pulse: _____			

	Normal	Abnormal	Explain Abnormalities
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	
Ears/nose/throat	<input type="checkbox"/>	<input type="checkbox"/>	
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	
Heart	<input type="checkbox"/>	<input type="checkbox"/>	
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	
Genitalia/hernia	<input type="checkbox"/>	<input type="checkbox"/>	
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	

### 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
<input type="checkbox"/>	<input type="checkbox"/>	Meets height/weight requirements.
<input type="checkbox"/>	<input type="checkbox"/>	Does not have uncontrolled heart disease, asthma, or hypertension.
<input type="checkbox"/>	<input type="checkbox"/>	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.
<input type="checkbox"/>	<input type="checkbox"/>	Has no uncontrolled psychiatric disorders.
<input type="checkbox"/>	<input type="checkbox"/>	Has had no seizures in the last year.
<input type="checkbox"/>	<input type="checkbox"/>	Does not have poorly controlled diabetes.
<input type="checkbox"/>	<input type="checkbox"/>	If less than 18 years of age and planning to scuba dive, does not have diabetes, asthma, or seizures.
<input type="checkbox"/>	<input type="checkbox"/>	<b>For high-adventure participants, I have reviewed with them the important supplemental risk advisory provided.</b>

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						
60	166	65	196	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

