21ST WORLD SCOUT JAMBOREE, BOY SCOUTS OF AMERICA
HEALTH AND MEDICAL RECORD

MAKE COPIES FOR YOURSELF AND YOUR WORLD SCOUT JAMBOREE SCOUTMASTER.

Original form must be returned. Photocopies will not be accepted.

I. IDENTIFICATION

Name ______________________________ ______________________ ______ _____

Last name First name Middle Name Date of birth (MM/DD/YYYY) Age Sex

Participant ❑ Staff ❑ Council number ____________ Regional subcamp or national ____________

Address ____

City ______________________ State________ Zip code __________

Health/accident insurance company__________ Policy number________ Religious preference__________

Scoutmaster__________ Personal physician__________ Phone number (____)__________

Home council name ______________ City/state ______________

IN CASE OF AN EMERGENCY:

Name______________________ Relationship______________________

Address ____

City ______________________ State________ Zip code __________

Home phone (____)__________ Business phone (____)__________ Extension (____)__________

II. EMERGENCY MEDICAL INFORMATION

Has or is subject to: (If yes, explain below.)

Yes	No		Yes	No		Yes	No		Yes	No	
❑	❑	Psychiatric disorders	❑	❑	Asthma	❑	❑	Anemia	❑	❑	Convulsions or seizures
❑	❑	Bleeding disorders	❑	❑	Hypertension	❑	❑	Severe infection	❑	❑	Cancer, leukemia, or lymphoma
❑	❑	Diabetes	❑	❑	Heart trouble	❑	❑	Fainting spells	❑	❑	Problem with immune system

❑ ❑ Any condition that may require special care, medication or diet

❑ ❑ Allergy to a medicine, food, plant, animal, or insect toxin

EXPLAIN: ____

____

III. IMMUNIZATIONS

For youth (under 18) required immunizations: Tetanus and diphtheria toxoids, measles, mumps and rubella, chicken pox (disease or immunization), and polio. For youth (under 18) recommended immunizations: measles booster at age 12 and hepatitis A and B. Youth and adults require a tetanus booster within 10 years. If had disease, put “D” and year of the disease. If immunized, check the box and put the year of the immunization.

Yes	No		Year	Yes	No		Year
❑	❑	Tetanus	_______	❑	❑	Rubella	_______
❑	❑	Diphtheria	_______	❑	❑	Polio	_______
❑	❑	Pertussis	_______	❑	❑	Chicken pox	_______
❑	❑	Measles	_______	❑	❑	Hepatitis A	_______
❑	❑	Mumps	_______	❑	❑	Hepatitis B	_______

THIS SPACE FOR OFFICE USE ONLY

Satisfaction of jamboree immunization requirements **MUST BE CONFIRMED** by council contingent leadership at least 30 days prior to arrival on site, and verified by jamboree medical personnel at check-in.

Name (Please print)____

Signature______________________________ Date ______________

IV. MEDICAL HISTORY

Check immunization 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, illness, surgery, or significant changes in condition of health of applicant since last complete examination. Are you aware of any current health problems? Yes ❑ No ❑

Has there been any surgery, injury, illness, allergy, or change in health status since last complete physical examination? Yes ❑ No ❑

Is there history or current disease or problem regarding: (For any "yes" answers give dates and full details below.)

	Yes	No	Year	Explain
Serious illness	❑	❑	____	____________
Serious injury	❑	❑	____	____________
Deformity	❑	❑	____	____________
Surgery	❑	❑	____	____________
Skin, glands	❑	❑	____	____________
Ears, eyes	❑	❑	____	____________
Nose, sinus	❑	❑	____	____________
Teeth	❑	❑	____	____________
Dentures	❑	❑	____	____________
Bridge	❑	❑	____	____________
Chest, lungs	❑	❑	____	____________
Heart	❑	❑	____	____________
Murmur	❑	❑	____	____________

	Yes	No	Year	Explain
Stomach, bowels	❑	❑	____	____________
Appendicitis	❑	❑	____	____________
Kidneys or urine	❑	❑	____	____________
Albumin	❑	❑	____	____________
Sugar	❑	❑	____	____________
Infection	❑	❑	____	____________
Bed-wetting	❑	❑	____	____________
Menstrual problems	❑	❑	____	____________
Hernia (rupture)	❑	❑	____	____________
Back, limbs, joints	❑	❑	____	____________
Sleepwalking	❑	❑	____	____________
Nervous condition	❑	❑	____	____________
Attention deficit disorder	❑	❑	____	____________
Other	❑	❑	____	____________

V. PARENTAL OR ADULT PARTICIPANT STATEMENT

Has it ever been necessary to restrict applicant's activities for medical reasons? Yes ❑ No ❑

If yes, EXPLAIN ______________________________

Does applicant take medicine (prescription or over the counter) on a regular basis? Yes ❑ No ❑

If yes, please list in detail:

Drug	Dosage	Route (Example: oral, injection, etc.)	Frequency

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

____

____

To the best of my knowledge, the information in sections I, II, III, IV, and V is accurate and complete. I request 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 the jamboree, subject to limitations noted herein. In the event of illness or accident in the course of such activity, I request that measures be initiated without delay as judgment of medical personnel dictates. I understand if I have a disqualifying mental or physical condition it eliminates my participation and I may not be able to attend the jamboree.

Parent or guardian must sign if applicant is under 18:

Parent or guardian ______________________________ Date signed ____________

Applicant's signature ______________________________ Date signed ____________

IMMEDIATELY BEFORE THE JAMBOREE, PLEASE UPDATE THIS SECTION WITH ANY NEW INFORMATION.

During the 30 days preceding the jamboree, has applicant taken any medication (prescription or non-prescription) that is NOT listed above?

Yes ❑ No ❑ If yes, list in detail: drug, dose, and date taken ______________________________

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VI. 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: high heat and humidity, high air particle count, more walking than normal, fatigue, and physical competition. Please be advised that electrical outlets for conditions such as sleep apnea, air conditioning, and any special diets will not be available at the site. Exposure to bee stings, ticks, and poisonous plants is very likely.

Please insist applicant furnish complete medical history (section IV of this form) before examination.

Review immunizations. For youth (under 18) **required** immunizations: tetanus and diphtheria toxoids, measles, mumps and rubella, chicken pox, and polio. For youth (under 18) **recommended** immunizations: A measles booster at age 12 and hepatitis A and B. For youth and adults, a tetanus booster within 10 years is required.

Date: ____

Height______________ Weight______________ Blood pressure_____ /_____ Pulse________________

VISION: Normal ________ Glasses______________ Contacts____________

HEARING: ❑ Normal ❑ Abnormal

LABORATORY (if indicated by history or exam): Fasting blood glucose_______ Hemoglobin__________ Urine________________

Mark below **if abnormal**, and give details below:

❑ Eyes, ears, nose ❑ Respiratory ❑ Genitourinary ❑ Neuropsychiatric

❑ Teeth ❑ Cardiovascular ❑ Musculoskeletal ❑ Growth, development

❑ Head, neck, thyroid ❑ Abdomen, hernia ❑ Skin, glands, hair ❑ Other (specify)____________

COMMENTS: (Abnormalities in exam)

____

____

____

____

VII. LICENSED HEALTH CARE PRACTITIONER'S EVALUATION AND ADVICE

Approved for participation in: ❑ Hiking and camping ❑ Competitive activities ❑ Sports/water activities ❑ All activities

Specify exceptions ____

Recommendations (Explain any restrictions or limitations; see medical alert section, and use if applicable.):________________

____

____

____

____

____

Physician's name (please print)_________________________________ Phone (_____) ______________

Address ____

City _________________________________ State__________ Zip code ____________

Signature of licensed health care practitioner* ______________________ Date ________________

License No.________________ State______________________ Expiration date________________

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

MEDICAL ALERT: It is essential that the jamboree medical personnel be aware of participants who have certain physical conditions that may require special consideration. Before February 15, 2007, any person with the following health conditions must submit a request for a medical alert: cardiac history, high blood pressure, sleep apnea, diabetes mellitus (with insulin or oral medication), obesity, asthma, sickle-cell anemia, hemophilia, severe blood dyscrasia, HIV infection, epileptic seizures, physical disability, or psychiatric illness. Using the form on the next page, signed by a licensed health care practitioner, mail before February 15, 2007, to:

Boy Scouts of America
Jamboree Medical Officer, S230
1325 West Walnut Hill Lane
P.O. Box 152079
Irving, TX 75015-2079

If a Medical Alert Is Required, Please Complete the Following:

1. Fill in all blanks.
2. State the patient's health condition—the reason for a medical alert request (outlined in section VII).
3. Note prescribed medication for condition(s). (See section IV.)
4. Make a brief statement on patient's behalf for participation.
5. Sign the form and date it.
6. Photocopy and mail the **photocopy** to:

   Jamboree Medical Officer, S230
   Boy Scouts of America
   1325 West Walnut Hill Lane
   P.O. Box 152079
   Irving, TX 75015-2079

   BEFORE February 15, 2007, for final approval.

ACCESSIBILITY FOR PEOPLE WITH DISABILITIES
Limited transportation is available for show events for severely handicapped wheelchair-confined Scouts. In general, everyone must be able to walk long distances or not participate in the show events. You must be in good physical condition to safely participate in the jamboree.

1. Patient's name (please print) ____________________
2. Comments about patient's condition (reason for medical alert request) ____________________
   ____
   ____
   ____
3. Comments about patient's need for full or limited participation____________________
   ____
   ____
   ____

Physician's name (please print)____________________ Phone (______) ____________________
Address ____________________
City ____________________ State________________ Zip code ____________________
Signature of licensed health care practitioner____________________ Date ____________________
License No.____________________ State____________________ Expiration date____________________

Review for Jamboree Activity

Date	Agency and activity	By	OK	Physician recheck needed	Results of recheck	Initial

Interval record: