Part A: Informed Consent, Release Agreement, and Authorization

A

Full name: Doe, John

Date of birth: 02-21-2009

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: John Doe Date: 3/2/2021

Parent/guardian signature for youth: Jack Doe Date: 3/2/2021

(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: Any registered T840 adult leader

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

B1

Full name: Doe, John

Date of birth: 02-21-2009

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

Age: 12 Gender: Male Height (inches): 58 Weight (lbs.): 95

Address: 123 Main Street

City: Coppell State: Texas ZIP code: 75019 Phone: 555-123-4567

Unit leader: Frank Miller Unit leader's mobile #: 972-824-6114

Council Name/No.: Circle Ten/ Western Horizon Unit No.: T840

Health/Accident Insurance Company: BCBS Policy No.: 1234-5678

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: Jack Doe Relationship: Father

Address: 123 Main Street, Coppell, TX 75019 Home phone: 555-223-4567 Other phone: 555-333-4567

Alternate contact name: Jackie Doe Alternate's phone: 555-444-4567

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 ☐ No ☐
☐	■	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/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 ☐ No ☐
☐	■	List all surgeries and hospitalizations	Last surgery date:
☐	■	List any other medical conditions not covered above	

Part B2: General Information/Health History

B2

Full name: Doe, John

Date of birth: 02-21-2009

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

Allergies/Medications

DO YOU USE AN EPINEPHRINE AUTOINJECTOR? Exp. date (if yes) _____ ☐ YES ☐ NO

DO 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	Yes	No	Allergies or Reactions	Explain
☐	■	Medication		☐	■	Plants	
■	☐	Food	Peanuts	■	☐	Insect bites/stings	Ants

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:

Jack Doe / _____

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	11-01-2020
■	☐		Pertussis	11-01-2020
■	☐		Diphtheria	11-01-2020
■	☐		Measles/mumps/rubella	11-01-2020
■	☐		Polio	11-01-2020
■	☐		Chicken Pox	11-01-2020
■	☐		Hepatitis A	11-01-2020
■	☐		Hepatitis B	11-01-2020
■	☐		Meningitis	11-01-2020
■	☐		Influenza	11-01-2020
■	☐		Other (i.e., HIB)	11-01-2020
☐	■		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: _____

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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: Doe, John

Date of birth: 02-21-2009

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	Peanuts

Yes	No	Allergies or Reactions	Explain
☐	■	Plants	
■	☐	Insect bites/stings	Ants, bite site infected

Height (inches)	Weight (lbs.)	BMI	Blood Pressure	Pulse
58	95		100 / 62	56

	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: Mary Smith Date: 03/02/2021

Examiner's printed name: Dr. Mary Smith

Address: 321 Main Street

City: Coppell State: TX ZIP code: 75019

Office phone: 555-456-7890

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

Practice: [redacted]

Physician: [redacted]

Patient: [redacted]

Date of birth: [redacted]

Today's Date: [redacted]

Name	Date
DiphtheriaTetanus	
DTaP	06/01/2007
DTaP	08/01/2007
DTaP	08/07/2007
DTaP	10/05/2007
DTaP	09/29/2008
DTaP	04/30/2012
HepA	
HepA	09/29/2008
HepA	10/19/2009
HepatitisB	
HepB	05/04/2007
HepB	07/09/2007
HepB	01/04/2008
HIB	
HIB	07/09/2007
HIB	09/04/2007
HIB	04/25/2008
HIB	07/18/2008
MMR	
MMR	09/29/2008

[redacted]

Name	Date
MMR	12/01/2008
Pneumococcal	
Pneumococcal.Conj	07/09/2007
Pneumococcal.Conj	09/04/2007
Pneumococcal.Conj	01/04/2008
Pneumococcal.Conj	04/25/2008
Pneumococcal.Conj	07/18/2008
PCV13	04/11/2011
Polio	
IPV	06/01/2007
IPV	08/01/2007
IPV	08/07/2007
IPV	10/05/2007
IPV	04/30/2012
Varicella	
Var	09/29/2008
Var	04/30/2012

The patient is not behind on any immunizations.

The following immunizations are due:

- HPV
- Meningococcal
- Flu_Seasonal
- tdBooster

BlueCross BlueShield

Providers: If Medicare is primary, pre certification is not required.

Please file medical claims with the Blue Cross and Blue Shield plan in the state where the services are rendered. If Medicare is primary, file claims to Medicare.

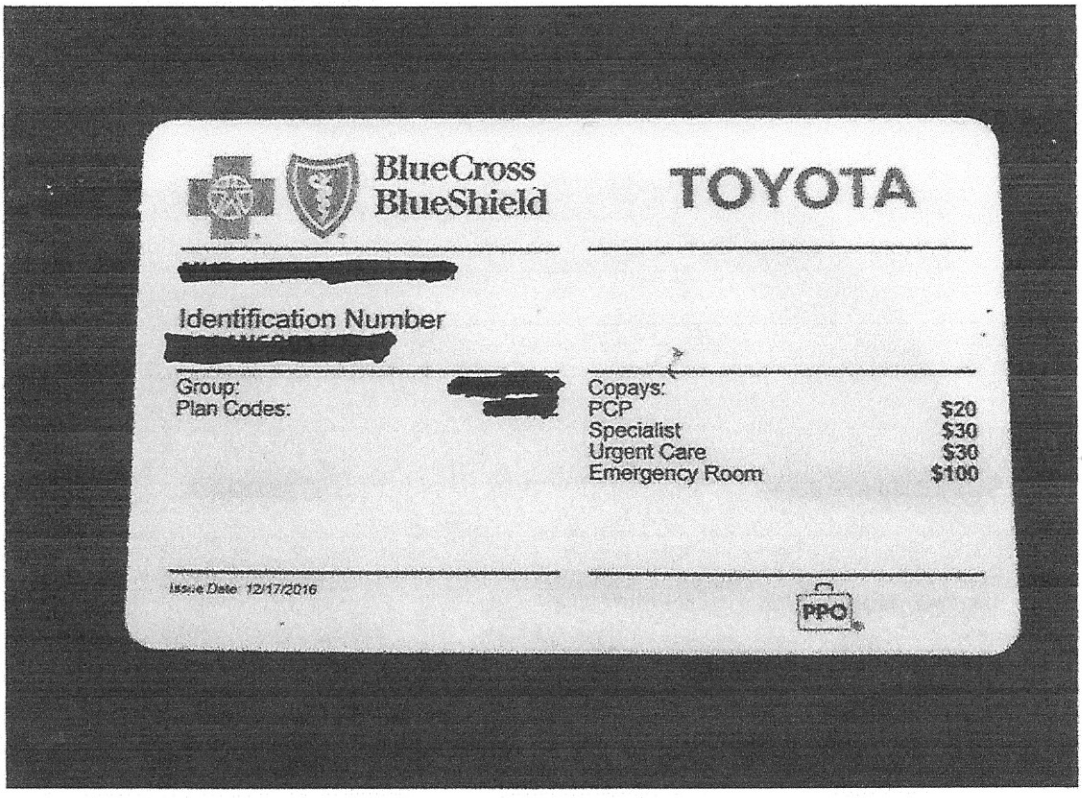
View provider listings, benefits, claims, and health and wellness information 24 hours a day 7 days a week by visiting anthem.com.

Possession of this card does not guarantee eligibility for benefits.

anthem.com

Member Services	1-800-456-4573
24/7 NurseLine	1-800-700-9184
Behavioral Hlth Resource Ctr	1-866-821-0654
Pre Certification	1-866-776-4793
High Tech Image/Sleep Mgmt	1-888-953-6703
Coverage While Traveling	1-800-810-2583
Provider Services	1-800-676-2583
MDLIVE*	1-888-632-2738

*Contracts directly with group



BlueCross BlueShield

TOYOTA

[redacted]

Identification Number

[redacted]

Group:

Plan Codes: [redacted]

Copays:

PCP	$20
Specialist	$30
Urgent Care	$30
Emergency Room	$100

Issue Date: 12/17/2016

PPO