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Part A: Informed Consent, Release Agreement, and Authorization

Full name:	High-adventure base participants: Expedition/crew No.:				
	or staff position:				
DOB:					
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 kno	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:				
I understand that, if any information I/we have provided is found to be inaccurate, it may am participating at Philmont, Philmont Training Center, Northern Tier, Florida Sea Base, risk advisories, including height and weight requirements and restrictions, and understaprograms if those requirements are not met. The participant has permission to engage inhealth-care provider. If the participant is under the age of 18, a parent or guardian's signals.	or the Summit Bechtel Reserve, I have also read and understand the supplemental nd that the participant will not be allowed to participate in applicable high-adventure n all high-adventure activities described, except as specifically noted by me or the				
Participant's signature:	Date:				
Parent/guardian signature for youth:(If participant is under	Date: the age of 18)				
Second parent/guardian signature for youth:	Date:				
(If required; for exam	ple, California)				
Complete this section for youth participants Adults Authorized to Take to and From Events:	s only:				
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				



Part B: General Information/Health History



			Expedition/crew No.: or staff position:			
DOB:						
Age:	Gender:	Height (inches):		Weight (lbs.):		
Address:						
City:	State:	ZIF	code:	Telephone:		
Unit leader:			Mobi	le phone:		
Council Name/No.:				Unit No.:		
Health/Accident Insuran	ce Company:		Policy No.:			
	e attach a photocopy of both s "none" above.	sides of the insuranc	e card. If yo	ou do not have medical insurance,	Ī	
In case of emerge	ncy, notify the person below:					
Name:			Relationship:			
Address:		Home phone	:	Other phone:		
Alternate contact name:	·		Alternate's pho	ne:		
Health Hist Do you currently have o	Ory r have you ever been treated for any of the	following?				
Yes No	Condition			Explain		

163	140	Condition	Explain
		Diabetes	Last HbA1c percentage and date:
		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	Last attack date:
		Lung/respiratory disease	
		COPD	
		Ear/eyes/nose/sinus problems	
		Muscular/skeletal condition/muscle or bone issues	
		Head injury/concussion	
		Altitude sickness	
		Psychiatric/psychological or emotional difficulties	
		Behavioral/neurological disorders	
		Blood disorders/sickle cell disease	
		Fainting spells and dizziness	
		Kidney disease	
		Seizures	Last seizure date:
		Abdominal/stomach/digestive problems	
		Thyroid disease	
		Excessive fatigue	
		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 B: General Information/Health History



Full name:						_ Exp	High-adventure base participants: Expedition/crew No.: or staff position:			
Alle Are you	ergi ı allergi	es/Med c to or do you ha	ications ve any adverse re	eaction to	any of the following?					
Yes	No	Allergies or F	Reactions		Explain	Yes	No	Allergies or Reaction	s Explain	
		Medication					-	Plants		
			-	•	ding any over-th		□IF	ADDITIONAL SPA	CE IS NEEDED, PLEASE ARATE SHEET AND ATTACH.	
		Medication		Dose	Frequency			R	eason	
_	_	-								
YE	s L	NO Non-pi	rescription med	ication a	dministration is autl	horized with	these e	xceptions:		
Adminis	stration	of the above me	dications is appro	oved for yo	outh by:					
		P:	arent/guardian sig	nature		/	MD/D	Ͻ, NP, or PA signature (if you	ur state requires signature)	
!		are NOT exp	oired, includ	ing inh		ens. You S			Make sure that they g any maintenance	
lmr	nıır	nization								
The foll	owing i	mmunizations are			A. Tetanus immunizati check yes and provid			st have been received with	in the last 10 years. If you had the disease,	
Yes	No	Had Disease		mmuniza	ation	D	ate(s)		t any additional information	
			Tetanus					about you	ır medical history:	
			Pertussis							
			Diphtheria							
			Measles/mump	s/rubella						
			Polio							
			Chicken Pox						WRITE IN THIS BOX	
			Hepatitis A						np or special activity.	
			Hepatitis B					Reviewed by:		
			Meningitis							
			Influenza						oval required: Yes No	
								Reason:		
	Other (i.e., HIB)							Approved by:		

Date:

Exemption to immunizations (form required)

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: You are being asked to certify that this indivi					High-adventure base participants: Expedition/crew No.: or staff position: ridual has no contraindication for participation inside a						
Examir	o p	f the natio ages or th	nal high-a e form pr	. For individuals who will adventure bases, please ovided by your patient.		_	_					
			Yes	No				Explain				
Medical	l restrict	ons to particip	ate									
Yes	No	Allergies or I	Reactions	Explain	Y	es N	o A	llergies or Reactions	Explain			
	-	Medication					PI	ants				
		ood					In:	sect bites/stings				
Height	(inches	s):	Weigh	t (lbs.): BMI:		Bloo	d Pres	ssure:/	Pulse:			
		Normal	Abnormal	Explain Abnormalities	Evo	min	o ric	Certification	•			
Eyes						aindicatio	ons for	participation in a Scouting e	examined this person and find experience. This participant			
Ears/no throat	ose/				True	False		ets height/weight requireme	Explain ents			
					_		+		art disease, asthma, or hypertension.			
Lungs							Has	s not had an orthopedic injunopedic surgery in the last s	iry, musculoskeletal problems, or six months or possesses a letter of apedic surgeon or treating physician.			
Heart							1	s no uncontrolled psychiatric				
					-		Has	Has had no seizures in the last year.				
Abdom	en						Doe	Does not have poorly controlled diabetes.				
Canitali	ia /h awai a							ess than 18 years of age and betes, asthma, or seizures.	d planning to scuba dive, does not hav			
Geriitali	a/hernia				_			r high-adventure participa portant supplemental risk	ants, I have reviewed with them the advisory provided.			
Muscul	oskeleta	ı			Examin	er's Sigr	nature:	:	Date:			
Neurolo	ogical				Provide	r printed	d name	e:				
					-			Sto	ute:ZIP code:			
Other					, –							

emergency vehicle/accessible roadway, you may not be allowed to participate.

Maximum weight for height:

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

