PERSONAL HEALTH AND MEDICAL RECORD
CLASS 1 AND CLASS 2

NAME Brian Konnor Ross

Height 49.5 Weight 56 lbs. Eye color Brown Hair color Auburn

CLASS 1 PERSONAL HEALTH AND MEDICAL HISTORY
(To be filled out annually by all participants)

To be filled out by parent, guardian, or adult participant. Please print in ink.

IDENTIFICATION

Name Brian Konnor Ross Date of birth 02/06/2000 Age 8 Sex Male

Name of parent or guardian Kenneth W. Ross Telephone 410-531-6889

Home address 10735 Judy Lane City Columbia State MD Zip 21044-4228

Business address 11100 Johns Hopkins Road City Laurel State MD Zip 20723-6099

If person named above is not available in the event of an emergency, notify 410-608-8226 Cell 443-451-1285 Work

Name Jennifer H. Ross Relationship Mother Telephone 410-531-6889 home

Name Beth Sheppard Relationship Family Friend Telephone 443-250-2382 Cell

Name of personal physician Dr. Rosalie Marinelli Telephone 410-997-6400

Personal health/accident insurance carrier CareFirst Blue Choice Policy No. XIC902253401 Group:4L96

Check all items that apply, **past or present,** to your health history. Explain any "Yes" answers.

ALLERGIES: Food, medicines, insects, plants Yes ☐ No ☒ Explain:

GENERAL INFORMATION:	Yes	No		Yes	No		Yes	No
ADHD (Attention-Deficit Hyperactivity Disorder)	☐	☒	Convulsions/seizures	☐	☒	Hemophilia	☐	☒
Asthma	☐	☒	Diabetes	☐	☒	High blood pressure	☐	☒
Cancer/leukemia	☐	☒	Heart trouble	☐	☒	Kidney disease	☐	☒

Explain:

Please list ALL medications taken in the 30 days **prior** to arrival at the Scouting activity where this form is to be used:

None

List any **medications to be taken at camp,** including drug, dosage, route (oral, injection, etc.), and frequency:

None

List any physical or behavioral conditions that may affect or limit full participation in swimming, backpacking, hiking long distances, or playing strenuous physical games: None

List equipment needed such as wheelchair, braces, glasses, contact lenses, etc.:

Immunizations: (Give date of last inoculation.)

Tetanus toxoid		Measles		Polio	11/30/01
OR DPT	11/30/04	OR MMR	11/30/04		
Hepatitis A		Varicella	9/1/01	OR Chicken pox	
Hepatitis B	6/22/01				

I give permission for full participation in BSA programs, subject to limitations noted herein.

In case of emergency, I understand every effort will be made to contact me (if participant is an adult, my spouse or next of kin). In the event I cannot be reached, I hereby give my permission to the licensed health-care practitioner selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child (or for me, if participant is an adult).

Date 05/11/08 Signature of parent/guardian or adult

Date updated Signature of parent/guardian or adult

Date updated Signature of parent/guardian or adult

Some hospitals require the parent/guardian signature to be notarized. Check with your BSA local council.

TROOP Pack 618

CAMPSITE

Class 1 (update annually for all participants). Activity: Day camp, overnight hike, or other programs not exceeding 72 hours, with level of activity similar to that of home or school. Medical care is readily available. Current personal health and medical summary (history) is attested by parents to be accurate. This form is filled out by all participants and is on file for easy reference.

Class 2 (required once every 36 months for all participants under 40 years of age). Activity: Resident camp or any other activity such as backpacking, tour camping, or recreational sports involving events lasting longer than 72 consecutive hours, with level of activity similar to that at home or school. Medical care is readily available.

> **Note:** Some states require an **annual** precamp medical evaluation. Your BSA local council service center can advise you about the requirements for your state.

If your child has had a medical evaluation **(physical examination)** within the last 36 months, a copy of the results of this examination must be attached to the health history for all participants in a camping experience lasting longer than 72 consecutive hours. If a copy is not available, a physical examination (using the Class 2 section of this form) must be scheduled by a *licensed health-care practitioner. This **medical evaluation** (physical examination) also is **required** if your **child** is currently **under medical care,** takes **a prescribed medication,** requires a **medically prescribed diet,** has had **an injury** or **illness during the past 6 months** that limited activity for a week or more, **has ever lost consciousness** during physical activity, or has **suffered a concussion from a head injury.**

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

THIS FORM IS NOT TO BE USED BY ADULTS OVER 40, BY HIGH-ADVENTURE PARTICIPANTS (USE FORM NO. 34412A), OR FOR NATIONAL SCOUT JAMBOREE (USE FORM NSJ-34412-01).

CLASS 2 MEDICAL EVALUATION

(Read additional requirements outlined on front of form.)

Name _____ Age _____

NOTE TO LICENSED HEALTH-CARE PRACTITIONERS*: The person being evaluated will be attending one or more weeks of camp that may include sleeping on the ground and participating in strenuous activities such as hiking, boating, and vigorous group games. Please review the health history with the participant for any interim changes. **Explain any "abnormal" evaluations.**

PHYSICAL EXAMINATION (To be filled out by a licensed health-care practitioner*)

Height _____ Weight _____ BP _____ / _____ Pulse _____

VISION: Normal _____ Glasses _____ Contacts _____

HEARING: Normal _____ Abnormal _____ Explain _____

Check box:	N	Abn		N	Abn		N	Abn
Growth development	☐	☐	Teeth	☐	☐	Genitalia	☐	☐
Skin	☐	☐	Cardiopulmonary system	☐	☐	Musculoskeletal	☐	☐
HEENT	☐	☐	Hernia	☐	☐	Neurobehavioral	☐	☐

Explain:

Limitations

Activity restrictions

Diet restrictions

Comment on any need for medical assistance devices:

Signature _____ Printed name _____ Date _____

Licensed health-care practitioner*

Address _____ Phone _____

City, State, Zip

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

INTERVAL RECORD	SCREENING EXAMINATION	
Date, Time, Place, Etc.	(Findings, diagnoses, treatment, instructions, disposition, etc.)	By

NAME

TROOP

CAMPSITE

#34414B

PHOTOCOPYING THIS FORM IS PERMITTED.

34414B
2007 Printing