Trail Life

Charter Organization: _____ **Submission Date:** _____

Troop Number: _____

This Medical Form is valid for 12 calendar months from the date of submission

HEALTH & MEDICAL RECORD

PART A: INFORMED CONSENT, RELEASE AGREEMENT, AND AUTHORIZATION

Note: This medical form is required by the Charter Organization to participate in Trail Life USA activities or events.

Participant Name: _____ **Date of Birth:** _____ **Age:** _____

Street Address: _____ **Phone:** _____

City: _____ **State:** _____ **Zip:** _____

INFORMED CONSENT, RELEASE AGREEMENT, AND AUTHORIZATION

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. *I give permission for full participation in Trail Life USA activities, except where specifically limited in writing herein. As far as I know, this health and medical form is correct and complete. I hereby give permission for designated leadership to administer prescribed and over-the-counter medications. In case of an emergency, I understand every effort will e made to contact me. In the event that I cannot be reached, I hereby give my permission to the licensed healthcare provider selected by the adult leader(s) to secure proper treatment, including related transportation, hospitalization, anesthesia, surgery, or injections of medication for my child, except as noted below. I agree to the release of records necessary for treatment.*

YOUTH PARTICIPANTS ONLY: ADULT TRANSPORTATION AUTHORIZATION

Please list any instructions or restrictions regarding who may or may not drive this youth to and from Trail Life meetings and events.

_____

_____

_____

_____

REQUIRED SIGNATURES & VALIDITY

Participant or Parent/Guardian Signature: _____ **Date:** _____
(Required if participant is under age 18)

Second Parent/Guardian Signature: _____ **Date:** _____
(If required by state law, e.g., California)

PART B1: EMERGENCY CONTACTS & INSURANCE INFO

Primary Emergency Contact:	Secondary Emergency Contact:	Alternate Emergency Contact:
Name: _____	**Name:** _____	**Name:** _____
Relationship: _____	**Relationship:** _____	**Relationship:** _____
Home Phone: _____	**Home Phone:** _____	**Home Phone:** _____
Cell Phone: _____	**Cell Phone:** _____	**Cell Phone:** _____

INSURANCE INFORMATION (Please attach a copy of both sides of your insurance card)

☐ *Member does not have health care coverage at this time. (If checked, skip below)*

Insurance Company #1: _____ **Policy Holder:** _____

Policy #: _____ **Group #:** _____ **Effective Date** _____

Insurance Company #2: _____ **Policy Holder:** _____

Policy #: _____ **Group #:** _____ **Effective Date** _____

PHYSICIAN & DENTIST INFORMATION

Primary Care Physician: _____ **Phone:** _____

Physician Address: _____

Dentist Name: _____ **Phone:** _____

Dentist Address: _____

Preferred Hospital: _____

PART B1 (CONTINUED): HEALTH HISTORY CHECKLIST

Please complete the following information regarding your health history. Do you currently have, or have you ever been treated for any of the following?

YES	NO	Condition / Explain	YES	NO	Condition / Explain
☐	☐	Asthma (Last Attack date: _____)	☐	☐	Fainting Spells / Dizziness / Vertigo
☐	☐	Diabetes (Last HbA1c: _____ %)	☐	☐	Thyroid Disease / Condition
☐	☐	Hypertension (High Blood Pressure)	☐	☐	Kidney / Urinary Disease
☐	☐	Heart Disease / Murmur / Pain / Infarction	☐	☐	Sickle Cell Disease / Trait
☐	☐	Stroke / TIA	☐	☐	Seizures (Last Seizure date: _____)
☐	☐	Lung / Respiratory Disease (COPD)	☐	☐	Sleep Disorders (CPAP? ☐ Y ☐ N)
☐	☐	Ear / Sinus Problems	☐	☐	Abdominal / Stomach / Digestive Problems
☐	☐	Muscular / Skeletal Condition	☐	☐	Surgery (Last Surgery date: _____)
☐	☐	Psychiatric / Emotional Difficulties	☐	☐	Serious Injury / Head Trauma / Concussion
☐	☐	Behavioral / Neurological Disorders	☐	☐	Excessive Fatigue with Exercise / Shortness of Breath
☐	☐	Bleeding / Blood Disorders	☐	☐	Other Medical Conditions (explain below)

Explain all 'Yes' answers:

_____

_____

PART B2: ALLERGIES & ADVERSE REACTIONS

Please list all known allergies, including those to any medication, food, and environment. If none are known, please write "none known." Include a description of the normal reaction and the best management of the reaction. Attach an additional page with this form as needed.

Are you allergic to or do you have any adverse reaction to any of the following?

☐ **Medication** ☐ **Food** ☐ **Plants** ☐ **Insect bites/stings** ☐ **Other**

List specific allergies, reactions, and management

1. Allergy: _____ **Normal Reaction:** _____ **Management:** _____

2. Allergy: _____ **Normal Reaction:** _____ **Management:** _____

PART B2: MEDICATIONS LIST

List all medications currently used. (If additional space is needed, please photocopy this part of the health form.) Inhalers and EpiPen information must be included, even if they are for occasional or emergency use only. If none, please write "None" below.

Medication Name	Strength	Frequency	Approx. Start Date	Reason for Medication

Bring enough medications in original containers. Do not stop maintenance medications unless instructed by a physician. Inhalers and EpiPens must be listed.

PART B2: RECOMMENDED IMMUNIZATIONS

Immunization	Immunized? (Y/N)	Date of Immunization	Had Disease? (Y/N)	Date of Disease
Tetanus	☐ Yes ☐ No	MM/YY: _____	☐ Yes ☐ No	MM/YY: _____
Pertussis	☐ Yes ☐ No	MM/YY: _____	☐ Yes ☐ No	MM/YY: _____
Diphtheria	☐ Yes ☐ No	MM/YY: _____	☐ Yes ☐ No	MM/YY: _____
Measles, Mumps, Rubella (MMR)	☐ Yes ☐ No	MM/YY: _____	☐ Yes ☐ No	MM/YY: _____
Polio	☐ Yes ☐ No	MM/YY: _____	☐ Yes ☐ No	MM/YY: _____
Chicken Pox (Varicella)	☐ Yes ☐ No	MM/YY: _____	☐ Yes ☐ No	MM/YY: _____
Hepatitis A & B	☐ Yes ☐ No	MM/YY: _____	☐ Yes ☐ No	MM/YY: _____
Meningitis & Influenza	☐ Yes ☐ No	MM/YY: _____	☐ Yes ☐ No	MM/YY: _____
Other (i.e., HIB)	☐ Yes ☐ No	MM/YY: _____	☐ Yes ☐ No	MM/YY: _____

MEDICATION ADMINISTRATION & AUTHORIZATIONS

No Trail Life youth member is allowed to self-medicate while participating in Trail Life USA events. The only exceptions are emergency use medications (e.g., Inhalers, Insulin, EpiPens) provided that the youth understands its use and the parent gives permission. Non-prescription over-the-counter medications are authorized except:

_____

☐ *I attest that the youth participant is able to self-administer emergency use medications*

Initial

Participant Signature: _____ **Date:** _____
(Parent/Guardian if youth)

MD/DO, NP, or PA Signature: _____ **Date:** _____
(if required by state law for youth meds)

PART C: PRE-PARTICIPATION PHYSICAL EXAM (HIGH ADVENTURE)

Licensed Healthcare Provider Note: This High Adventure Medical Exam Form is required by the Charter Organization and/or camp leadership to participate in Trail Life USA activities or events that exceed 72 hours in duration, or include high altitude or high-exertion activities. **Parts A and B MUST accompany this form.**

Participant Name: _____ **Date of Birth:** _____ **Age:** _____

Height	Weight	BMI	Blood Pressure	Pulse	Vision	Hearing	Glasses/ Contacts
_____ in.	_____ lb.	_____	____ / ____	_____ bpm	☐ Normal ☐ Abnormal	☐ Normal ☐ Abnormal	☐ Glasses ☐ Contacts

PRE-PARTICIPATION CLINICAL EVALUATION			
Growth, Development	☐ Normal ☐ Abnormal	Cardiovascular	☐ Normal ☐ Abnormal
Skin, Glands, Hair	☐ Normal ☐ Abnormal	Abdomen, Hernia	☐ Normal ☐ Abnormal
Head, Neck, Thyroid	☐ Normal ☐ Abnormal	Genitourinary	☐ Normal ☐ Abnormal
Eyes, Ears, Nose	☐ Normal ☐ Abnormal	Skeletomuscular	☐ Normal ☐ Abnormal
Teeth, Tonsils	☐ Normal ☐ Abnormal	Neuropsychiatric	☐ Normal ☐ Abnormal
Respiratory	☐ Normal ☐ Abnormal	Other (_____)	☐ Normal ☐ Abnormal

Height/Weight Restrictions
If you exceed the recommended 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, the Charter Organization may not allow you to participate.

HIGH ADVENTURE HEIGHT-WEIGHT LIMITS (COMPLIANCE TABLE)

Ht (in)	Max Wt	Ht (in)	Max Wt	Ht (in)	Max Wt	Ht (in)	Max Wt
60	166 lbs	65	195 lbs	70	226 lbs	75	260 lbs
61	172 lbs	66	201 lbs	71	233 lbs	76	267 lbs
62	178 lbs	67	207 lbs	72	239 lbs	77	274 lbs
63	183 lbs	68	214 lbs	73	246 lbs	78	281 lbs
64	189 lbs	69	220 lbs	74	252 lbs	79+	295 lbs

Dietary Restrictions: _____

Approved for Participation in: ☐ Hiking ☐ Competitive Sports ☐ Water Activities ☐ All Activities

Exceptions, Restrictions, or Limitations: _____

LICENSED HEALTH CARE PROVIDER AFFIRMATION & SIGNATURE

Examiner Certification I certify that I have reviewed the health history, examined this person, and find no medical contraindications for participation in a strenuous High Adventure Trail Life experience. The applicant will participate in activities that may include high altitude, extreme weather, exposure, fatigue, and remote conditions where medical care is not readily available. I hereby affirm that upon my examination, there are no restrictions or limitations to his participation.

Provider Signature: _____ **Date of Exam:** _____

Printed Name of Examiner: _____ **Office Phon** _____

Address, City, State, Zip: _____

This High Adventure Medical Exam Form is valid for 12 calendar months from the date of the exam.