



## Youth Health and Medical Form

**Note:** An additional medical form is required for Trail Life USA activities or events that exceed 72 hours in duration, or include high altitude or high-exertion activities. The High Adventure Medical Form requires the examination by and the signature of a doctor or health care professional.

### PARTICIPANT INFORMATION

Participant Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Phone \_\_\_\_\_ Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Troop Leader \_\_\_\_\_ Troop # \_\_\_\_\_

### EMERGENCY CONTACTS

Mother's Name \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Father's Name \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**Other Emergency Contact if parents cannot be reached:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

### INSURANCE INFORMATION

Member does not have health care coverage at this time. Continue to next section.

Member has health care coverage as listed below.

Insurance Company #1 \_\_\_\_\_ Policy # \_\_\_\_\_

Policy Holder \_\_\_\_\_ Group # \_\_\_\_\_ Effective Date \_\_\_\_\_

Insurance Company #1 \_\_\_\_\_ Policy # \_\_\_\_\_

Policy Holder \_\_\_\_\_ Group # \_\_\_\_\_ Effective Date \_\_\_\_\_

**Please include a copy of both sides of your insurance card when submitting this form.**

**PHYSICIAN INFORMATION**

Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_

Physician Address, City, State, Zip \_\_\_\_\_

Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Dentist Address, City, State, Zip \_\_\_\_\_

Preferred Hospital \_\_\_\_\_

**ALLERGIES**

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.

Allergy	Reaction/Management

**HEALTH HISTORY**

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
		Asthma Last Attack ( <i>mm/yy</i> ):	
		Diabetes Last HbA1c (%):	
		Hypertension ( <i>High Blood Pressure</i> )	
		Heart Disease, Heart Attack, Chest Pain, Murmur	
		Stroke/TIA	
		Lung/Respiratory Disease	
		Ear/Sinus Problems	
		Muscular/Skeletal Condition	

		Psychiatric/Psychological/Emotional Difficulties		
		Behavioral/Neurological Disorders		
		Bleeding Disorders		
		Fainting Spells		
		Thyroid Disease		
		Kidney Disease		
		Sickle Cell Disease		
		Seizures	Last Seizure (mm/yy):	
		Sleep Disorders	Use CPAP?	
		Abdominal/Digestive Problems		
		Surgery	Last Surgery (mm/yy):	
		Serious Injury		
		Excessive Fatigue/Shortness of Breath with Exercise		
		Other		

### IMMUNIZATIONS

The following immunizations are recommended. For each item, indicate if you have been immunized, the date of the immunization (MM/YY), if you have had the disease, and the date of the disease (MM/YY).

Immunized?		Immunization	Date of Immunization	Had Disease?		Date of Disease
Yes	No			Yes	No	
		Tetanus				
		Pertussis				
		Diphtheria				
		Measles				
		Mumps				
		Rubella				
		Polio				

		Chicken Pox				
		Hepatitis A				
		Hepatitis B				
		Meningitis				
		Influenza				
		Other (i.e., HIB)				

**MEDICATIONS**

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	Strength	Frequency	Approx Start Date	Reason

Administration of the above medications and such over-the-counter medications as may be deemed necessary for the health and safety of Participant is approved by (if required by your state):

\_\_\_\_\_  
 Parent/Guardian Signature

\_\_\_\_\_  
 MD/DO, NP, or PA signature (where required by state law for the dispensation of medications by a non-parent)

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.

No Trail Life youth member is allowed to self-medicate while participating in a Trail Life event. The only exceptions include emergency use medications such as by an inhaler, insulin syringe, or epi-pen, provided that the Trailman understands its proper use. Parents must indicate in writing that the youth is in possession of such medication and possesses the knowledge and ability to administer it to himself.

I do hereby attest that the youth participant is able to self-administer the above-listed emergency use medications in case of emergency if no approved adult leader is present to administer them.

\_\_\_\_\_  
*Parent/Guardian Signature*

**ADULTS AUTHORIZED TO TAKE YOUTH TO AND FROM EVENTS**

Name \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

**ADULTS NOT AUTHORIZED TO TAKE YOUTH TO AND FROM EVENTS**

Name \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

**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 Trail Life USA leadership to administer prescribed and over-the-counter medications.

In case of an emergency, I understand every effort will be 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 Trail Life USA 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.

**NOTES**

\_\_\_\_\_  
*Participant Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Parent/Guardian Signature (if participant is under age 18)*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Second Parent/Guardian Signature (if required by state law, as in CA)*

\_\_\_\_\_  
*Date*

***This Weekend Health and Medical Record is valid for 12 calendar months.***