

MEDICAL INFORMATION

Camp Squanto operates in compliance with the Boy Scouts of America Plans and Procedures for Operating a Resident Boy Scout Camp, Commonwealth of Massachusetts Safety Standards for Recreational Camps for Children (105CMR 430.000 through 105 CMR 430.830), and Old Colony Council Camp Policies.

Camp Squanto has developed a comprehensive and detailed Health and Safety Guide, which contains policies covering emergencies, safety issues, Health Lodge operations, medical treatment, discipline, and background checks.

A copy of this complete guide is available for your review at the Old Colony Council office at 2438 Washington St., Canton MA (781) 828-8360, or during summer camp operation at Camp Squanto Director's Office and it's Health Lodge.

MEDICAL FORM

The following is the Policy at Camp Squanto regarding Medical Forms:

- All Scouts and Leaders, under age 40, attending camp **MUST** have a medical exam performed by a physician within 24 months of your camp arrival date, however, your Medical form must be revised each 12 months. Therefore, your medical form must be signed by a physician within the past 12 months but you need only to have had a physical exam within the last 24 months.
- All leaders over age 40 attending camp **MUST** have a medical exam performed by a physician within 12 months of your camp arrival date.
- All completed medical forms are presented to the Health Lodge upon arrival. **SCOUTS AND ADULT LEADERS WILL NOT BE PERMITTED TO REMAIN IN CAMP WITHOUT A PROPERLY COMPLETED HEALTH RECORD. CURRENT IMMUNIZATION DATES ARE REQUIRED BY STATE LAW.** Check marks or words "Up to date" are not acceptable. **ALL MEDICATIONS MUST COME IN ITS ORIGINAL CONTAINERS. ALL MEDICAL FORMS MUST BE SIGNED BY A PHYSICIAN, APPLICANT AND A PARENT/GUARDIAN IF UNDER 18, WITHIN THE LAST TWELVE MONTHS.**

Again, if you are under 40 you need only to have had a physical within the past two years, but the form still needs to be signed by a physician within the last year.

TREATMENT OF MILDLY ILL CAMPERS

Mildly ill campers will be treated using good nursing judgment following procedures approved by our Health Care Consultant. Administration of medication will be done by our Camp Health Supervisor following the directions provided by the prescription label or by a written Doctor's order and for non-prescription products by the product label or by a Doctor's note. **NO EXCEPTIONS.** Emergency health care will be provided on site by trained first aid staff, followed up by our Health Lodge staff and transport to Jordan Hospital if deemed necessary.

PERSONAL HEALTH AND MEDICAL RECORD FORM - Class 3

I. Identification Age: Sex:

Name: _____
 Last Name First Name Initial

Address _____
 City State Zip

Date of Birth _____

Health/Accident Insurance _____ Policy #: _____

In an emergency notify:
 Name: _____ Relation: _____
 Address _____ Home Phone _____
 City & State _____ Other Phone _____

III. PARENTAL STATEMENT

Has it ever been necessary to restrict applicant's activities for medical reasons? NO YES

Does applicant take medicine regularly or have special care? NO YES

If yes, explain: _____

To the best of my knowledge the information in sections I, II, III, IV, and VI is accurate and complete. I request a licensed health-care practitioner to examine applicant, to give needed immunization, and to furnish requested information to other agencies as needed. I give my permission for full participation in BSA programs, subject to limitations noted herein. In the event of illness or accident in the course of such activity. I request that measures be instituted without delay as judgement of medical personnel dictates.

APPLICANT SIGNATURE (IF OVER 18) _____

PARENT OR GUARDIAN SIGNATURE _____
 (Must Sign if applicant is 18 or younger)

Date signed _____ Must be within 12 months

VI. MEDICAL HISTORY

Date of most recent complete physical examination Month _____ Year _____
 (Within the last 24 months for campers/within 12 months for adults over 40 years of age)

Are you aware of any health problems? NO YES

Now under medical care or taking medicines? NO YES

Has there been any surgery, injury, illness, allergy, or change in health status since last complete physical examination? NO YES

Give dates and full details below for any "yes" answers

IS THERE DISEASE OF (OR PAST OR PRESENT HISTORY OF)

	NO	YES	YEAR	DETAILS/MEDICINES
Serious Illness	<input type="checkbox"/>	<input type="checkbox"/>		
Serious Injury	<input type="checkbox"/>	<input type="checkbox"/>		
Deformity	<input type="checkbox"/>	<input type="checkbox"/>		
Surgery	<input type="checkbox"/>	<input type="checkbox"/>		
Skin, glands	<input type="checkbox"/>	<input type="checkbox"/>		
Ears, eyes	<input type="checkbox"/>	<input type="checkbox"/>		
Nose, Sinus	<input type="checkbox"/>	<input type="checkbox"/>		
Teeth, Tonsils	<input type="checkbox"/>	<input type="checkbox"/>		
Dentures	<input type="checkbox"/>	<input type="checkbox"/>		
Bridge	<input type="checkbox"/>	<input type="checkbox"/>		
Chest, Lungs	<input type="checkbox"/>	<input type="checkbox"/>		
Heart	<input type="checkbox"/>	<input type="checkbox"/>		
Mumor	<input type="checkbox"/>	<input type="checkbox"/>		
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>		
Stomach, bowels	<input type="checkbox"/>	<input type="checkbox"/>		
Appendicitis	<input type="checkbox"/>	<input type="checkbox"/>		
Kidneys or urine	<input type="checkbox"/>	<input type="checkbox"/>		
Albumin	<input type="checkbox"/>	<input type="checkbox"/>		
Sugar	<input type="checkbox"/>	<input type="checkbox"/>		
Infection	<input type="checkbox"/>	<input type="checkbox"/>		
Bed-wetting	<input type="checkbox"/>	<input type="checkbox"/>		
Menstrual problems	<input type="checkbox"/>	<input type="checkbox"/>		
Hernia (rupture)	<input type="checkbox"/>	<input type="checkbox"/>		
Back, limbs, joints	<input type="checkbox"/>	<input type="checkbox"/>		
Sleepwalking	<input type="checkbox"/>	<input type="checkbox"/>		
Nervous condition	<input type="checkbox"/>	<input type="checkbox"/>		
Other (explain)				

II. EMERGENCY MEDICAL INFORMATION

Has or is subject to: (check and give details)

Allergy to a medicine, food, plant, animal, or insect toxin

Any condition that may require special care, medication or diet

ADHD (Attention Deficit Hyperactive Disorder)

Asthma Convulsions Heart trouble Bleeding Disorders

Diabetes Fainting Spells Dentures Contact Lenses

Explain: _____

IV. IMMUNIZATIONS: Must be completed (Up to date is not accepted)

	DATE mm/dd/yy	DATE mm/dd/yy
Td: _____ (within 10 years)		Hep B #1: _____
DpT: _____		#2: _____
MMR #1: _____		#3: _____
#2: _____		
Polio #1: _____		Chicken Pox _____
#2: _____		(Varicella) _____
#3: _____		
#4: _____		
#5: _____		

V. LICENSED HEALTH-CARE PRACTITIONER'S EVALUATION AND ADVICE

Approved for participation in

Hiking and camping Water Activities

Competitive sports All Activities

Specify exceptions: _____

Recommendations (explain any restrictions OR limitations): _____

Signed: _____ **Date:** _____

Physician Name: _____ Number: _____

Signature must be dated within the last 12 months

*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.

VII. HEALTH EXAMINATION

Licensed Health-Care Practitioner

The applicant will be participating in a strenuous activity that will include one or more of the following conditions: athletic competition, adventure challenge or wilderness expedition (afoot or afloat) that may include high altitude, extreme weather conditions, cold water, exposure, fatigue, and/or remote conditions where readily available medical care cannot be assured.

- Please insist applicant furnish complete medical history (VI) before exam.
- Review immunization, for youth (18 or younger) tetanus and diphtheria toxoids, measles, mumps, and rubella vaccines, and trivalent oral polio vaccine are required; youth and adults must have had tetanus booster within 10 years. A measles booster is recommended at age 12
- After completing section VII, summarize any restrictions and/or recommendations in sections II and V.

VISION Normal Abnormal

HEARING Normal Abnormal

DATE: _____

Height _____ Glasses

Weight _____ Contacts

B.P. _____

Pulse _____

Check box if normal: circle if abnormal and give details below:

<input type="checkbox"/> Growth, development	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Teeth, tonsils
<input type="checkbox"/> Skin, glands, hair	<input type="checkbox"/> Skeletomuscular	<input type="checkbox"/> Respiratory
<input type="checkbox"/> Head, neck, thyroid	<input type="checkbox"/> Neuropsychiatric	<input type="checkbox"/> Cardiovascular
<input type="checkbox"/> Eyes, ears, nose	<input type="checkbox"/> Abdomen, hernia, rings	<input type="checkbox"/> Other

Comments: _____

MEDICAL SCREENING: (TO BE COMPLETED BY CAMP STAFF)

DATE: _____ PERFORMED BY: _____

COMMENTS: _____

Camp Squanto operates in compliance with Boy Scouts of America Plans and Procedures for Operating a Resident Boy Scout Camp, Commonwealth of Massachusetts Safety Standards for Recreational Camps for Children (105 CMR 430.000 through 105 CMR 430.830), and Old Colony Camp Policies.

Camp Squanto has developed a complex and detailed Health and Safety Guide which contains policies covering emergencies, safety Health Lodge operations, medical treatment, discipline, and background checks.

A copy of this complete guide is available for your review at the Old Colony Council office at 2438 Washington Street, Canton, MA (1-781-828-8360) or during summer camp operation at Camp Squanto Director's Office and its Health Lodge. In brief, mildly ill campers will be treated using good nursing judgment following procedures approved by our Health-Care Consultant. Administering of medication will be done by our Camp Health Supervisor following the directions provided by the prescription label or by a written Doctor's order. For non-prescription products by the product label or by a Doctor's order. NO EXCEPTIONS. Emergency healthcare will be provided on site by trained first aid staff, followed up by our Health Lodge Staff, and transport to Jordan Hospital if deemed necessary.

IN CASE OF EMERGENCY, PLEASE NOTIFY US BY:

Mother _____	Home # _____	Work # _____
	Cell # _____	Beeper # _____
Father _____	Home # _____	Work # _____
	Cell # _____	Beeper # _____
Guardian _____	Home # _____	Work # _____
	Cell # _____	Beeper # _____

Please notify both parents following the Camp's policy

In the event we cannot reach any of the above, call:

Name: _____ Address: _____
 Relationship: _____ Phone #: _____ Alternate #: _____

If you will be vacationing or staying at another location other than your residence, please provide the following:

Location: _____ Address: _____
 Phone #: _____ Dates: _____

MEDICATIONS: Please list below all medications you or your son/daughter has brought to camp. Medications must be in their original containers, NO EXCEPTIONS.

	NAME OF MEDICATION	DOSAGE*
1	_____	_____
2	_____	_____
3	_____	_____
4	_____	_____
5	_____	_____
6	_____	_____

* If given as PRN(as needed) you must define what "as needed" is for you or your son/daughter. If dosage is different that product's label, then a written Doctor's order must accompany this form.

This form completed by _____ SIGN _____ DATE _____
PRINT PARENT/GUARDIAN NAME **Must be within 12 months**

PERSONAL HEALTH & MEDICAL RECORD FORM - ADULT < 72 HOURS

I. Identification

Age: Sex:

Name: _____
 Last Name First Name Initial

Address _____
 City _____ State _____ Zip _____

Date of Birth _____

Health/Accident Insurance _____ Policy #: _____

In an emergency notify:

Name: _____ Relation: _____

Address _____ Home Phone _____

City & State _____ Other Phone _____

III. PARENTAL STATEMENT

Has it ever been necessary to restrict applicant's activities for medical reasons? NO YES

Does applicant take medicine regularly or have special care? NO YES

If yes, explain: _____

To the best of my knowledge the information in sections I, II, III, IV, and VI is accurate and complete.

I request a licensed health-care practitioner to examine applicant, to give needed immunization, and to furnish requested information to other agencies as needed. I give my permission for full participation in BSA programs, subject to limitations noted herein. In the event of illness or accident in the course of such activity. I request that measures be instituted without delay as judgement of medical personnel dictates.

APPLICANT SIGNATURE _____

Date signed _____ **Must be within 12 months**

VI. MEDICAL HISTORY

Date of most recent complete physical examination Month _____ Year _____

(Within the last 24 months for campers/within 12 months for adults over 40 years of age)

Are you aware of any health problems? NO YES

Now under medical care or taking medicines? NO YES

Has there been any surgery, injury, illness, allergy, or change in health status since last complete physical examination? NO YES

Give dates and full details below for any "yes" answers

IS THERE DISEASE OF (OR PAST OR PRESENT HISTORY OF)

	NO	YES	YEAR	DETAILS/MEDICINES
Serious Illness	<input type="checkbox"/>	<input type="checkbox"/>		
Serious Injury	<input type="checkbox"/>	<input type="checkbox"/>		
Deformity	<input type="checkbox"/>	<input type="checkbox"/>		
Surgery	<input type="checkbox"/>	<input type="checkbox"/>		
Skin, glands	<input type="checkbox"/>	<input type="checkbox"/>		
Ears, eyes	<input type="checkbox"/>	<input type="checkbox"/>		
Nose, Sinus	<input type="checkbox"/>	<input type="checkbox"/>		
Teeth, Tonsils	<input type="checkbox"/>	<input type="checkbox"/>		
Dentures	<input type="checkbox"/>	<input type="checkbox"/>		
Bridge	<input type="checkbox"/>	<input type="checkbox"/>		
Chest, Lungs	<input type="checkbox"/>	<input type="checkbox"/>		
Heart	<input type="checkbox"/>	<input type="checkbox"/>		
Murmur	<input type="checkbox"/>	<input type="checkbox"/>		
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>		
Stomach, bowels	<input type="checkbox"/>	<input type="checkbox"/>		
Appendicitis	<input type="checkbox"/>	<input type="checkbox"/>		
Kidneys or urine	<input type="checkbox"/>	<input type="checkbox"/>		
Albumin	<input type="checkbox"/>	<input type="checkbox"/>		
Sugar	<input type="checkbox"/>	<input type="checkbox"/>		
Infection	<input type="checkbox"/>	<input type="checkbox"/>		
Bed-wetting	<input type="checkbox"/>	<input type="checkbox"/>		
Menstrual problems	<input type="checkbox"/>	<input type="checkbox"/>		
Hernia (rupture)	<input type="checkbox"/>	<input type="checkbox"/>		
Back, limbs, joints	<input type="checkbox"/>	<input type="checkbox"/>		
Sleepwalking	<input type="checkbox"/>	<input type="checkbox"/>		
Nervous condition	<input type="checkbox"/>	<input type="checkbox"/>		
Other (explain)				

II. EMERGENCY MEDICAL INFORMATION

Has or is subject to: (check and give details)

Allergy to a medicine, food, plant, animal, or insect toxin

Any condition that may require special care, medication or diet

ADHD (Attention Deficit Hyperactive Disorder)

Asthma Convulsions Heart trouble Bleeding Disorders

Diabetes Fainting Spells Dentures Contact Lenses

Explain: _____

IV. IMMUNIZATIONS: Must be completed (Up to date is not accepted)

	DATE mm/dd/yy	DATE mm/dd/yy
Td:	____ / ____ / ____ (within 10 years)	Hep B #1: ____ / ____ / ____
DpT:	____ / ____ / ____	#2: ____ / ____ / ____
MMR #1:	____ / ____ / ____	#3: ____ / ____ / ____
#2:	____ / ____ / ____	
Polio #1:	____ / ____ / ____	Chicken Pox
#2:	____ / ____ / ____	(Varicella) Disease/Immun
#3:	____ / ____ / ____	
#4:	____ / ____ / ____	
#5:	____ / ____ / ____	

MEDICAL SCREENING: (TO BE COMPLETED BY CAMP STAFF)

DATE: _____ PERFORMED BY: _____

COMMENTS _____

Camp Squanto operates in compliance with Boy Scouts of America Plans and Procedures for Operating a Resident Boy Scout Camp, Commonwealth of Massachusetts Safety Standards for Recreational Camps for Children (105 CMR 430.000 through 105 CMR 430.830), and Old Colony Camp Policies.

Camp Squanto has developed a complex and detailed Health and Safety Guide, which contains policies covering emergencies, safety, Health Lodge operations, medical treatment, discipline, and background checks.

A copy of this complete guide is available for your review at the Old Colony Council office at 2438 Washington Street, Canton, MA (1-781-828-8360) or during summer camp operation at Camp Squanto Director's Office and its Health Lodge. In brief, mildly ill campers will be treated using good nursing judgment following procedures approved by our Health-Care Consultant. Administering of medication will be done by our Camp Health Supervisor following the directions provided by the prescription label or by a written Doctor's order. For non-prescription products by the product label or by a Doctor's order. **NO EXCEPTIONS.** Emergency healthcare will be provided on site by trained first aid staff, followed up by our Health Lodge Staff, and transport to Jordan Hospital if deemed necessary.

IN CASE OF EMERGENCY, PLEASE NOTIFY US BY:

Name: _____	Home # _____	Work # _____
Relation: _____	Cell # _____	Beeper # _____
Name: _____	Home # _____	Work # _____
Relation: _____	Cell # _____	Beeper # _____
Name: _____	Home # _____	Work # _____
Relation: _____	Cell # _____	Beeper # _____

In the event we cannot reach any of the above, call:

Name: _____ Address: _____
 Relationship: _____ Phone #: _____ Alternate #: _____

If you will be vacationing or staying at another location other than your residence, please provide the following:

Location: _____ Address: _____
 Phone #: _____ Dates: _____

MEDICATIONS: Please list below all medications you or your son/daughter has brought to camp. Medications must be in their original containers, NO EXCEPTIONS.

	NAME OF MEDICATION	DOSAGE*
1	_____	_____
2	_____	_____
3	_____	_____
4	_____	_____
5	_____	_____
6	_____	_____

* If given as PRN(as needed) you must define what "as needed" is for you or your son/daughter. If dosage is different that product's label, then a written Doctor's order must accompany this form.

This form completed by _____ SIGN _____ DATE _____
Must be within 12 months