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.

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 detaile 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 (1-781-828-8380) 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 oder. 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 thei 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 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 practioner 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 helath 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	☐	☐		
Serious injury	☐	☐		
Deformity	☐	☐		
Surgery	☐	☐		
Skin, glands	☐	☐		
Ears, eyes	☐	☐		
Nose, Sinus	☐	☐		
Teeth, Tonsils	☐	☐		
Dentures	☐	☐		
Bridge	☐	☐		
Chest, Lungs	☐	☐		
Heart	☐	☐		
Mumur	☐	☐		
Rhuematic Fever	☐	☐		
Stomach, bowels	☐	☐		
Appendicitis	☐	☐		
Kidneys or urine	☐	☐		
Albumin	☐	☐		
Sugar	☐	☐		
Infection	☐	☐		
Bed-wetting	☐	☐		
Menstrual problems	☐	☐		
Hernia (rupture)	☐	☐		
Back, limbs, joints	☐	☐		
Sleepwalking	☐	☐		
Nervous condition	☐	☐		
Other (explain)				

COMPLETE REVERSE SIDE

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 PRACTIONER'S EVALUATION AND ADVICE

Approved for participation in

☐ Hiking and camping ☐ Water Activities

☐ Competitive sports ☐ All Activities

Specify exceptions: ______________

Recommendations (explain any rescrictions OR limitations): ______________

Date: ______________

Signed: ______________

Physician Name: ______________ Number: ______

Signature must be dated within the last 12 months

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

VII. HEALTH EXAMINATION

Licensed Health-Care Practioner

> The applicant will be participating in a strenous 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 redily 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 reccomended at age 12
- After completing section VII, summarize any restrictions and/or recommendations in sections II and V.

DATE: ______
Height ______
Weight ______
B.P. ______
Pulse ______

VISION: Normal ☐ Glasses ☐ Contacts ☐

HEARING: Normal ☐ Abnormal ☐

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

☐ Growth, development ☐ Genitourinary ☐ eeth, tonsils

☐ Skin, glands, hair ☐ Skeletomuscular ☐ espiratory

☐ Head, neck, thyroid ☐ Neuropsychiatric ☐ :ardiovascular

☐ Eyes, ears, nose ☐ Abdomen, hernia, rings ☐ Other

Comments: ______________

MEDICAL SCREENING: (TO BE COMPLETED BY CAMP STAFF)

DATE: ______ PERFORMED BY: ______

COMMENTS ______________