

Part A: Informed Consent, Release Agreement, and Authorization

Full name: _____
DOB: _____

High-adventure base participants:
Expedition/crew No.: _____
or staff position: _____

Informed Consent, Release Agreement, and Authorization

I understand that participation in Scouting activities involves the risk of personal injury, including death, due to the physical, mental, and emotional challenges in the activities offered. Information about those activities may be obtained from the venue, activity coordinators, or your local council. I also understand that participation in these activities is entirely voluntary and requires participants to follow instructions and abide by all applicable rules and the standards of conduct.

In case of an emergency involving me or my child, I understand that efforts will be made to contact the individual listed as the emergency contact person by the medical provider and/or adult leader. In the event that this person cannot be reached, permission is hereby given to the medical provider selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for me or my child. Medical providers are authorized to disclose protected health information to the adult in charge, camp medical staff, camp management, and/or any physician or health-care provider involved in providing medical care to the participant. Protected Health Information/Confidential Health Information (PHI/CHI) under the Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. §§160.103, 164.501, etc. seq., as amended from time to time, includes examination findings, test results, and treatment provided for purposes of medical evaluation of the participant, follow-up and communication with the participant's parents or guardian, and/or determination of the participant's ability to continue in the program activities.

(If applicable) I have carefully considered the risk involved and hereby give my informed consent for my child to participate in all activities offered in the program. I further authorize the sharing of the information on this form with any BSA volunteers or professionals who need to know of medical conditions that may require special consideration in conducting Scouting activities.

With appreciation of the dangers and risks associated with programs and activities, on my own behalf and/or on behalf of my child, I hereby fully and completely release and waive any and all claims for personal injury, death, or loss that may arise against the Boy Scouts of America, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with any program or activity.

I also hereby assign and grant to the local council and the Boy Scouts of America, as well as their authorized representatives, the right and permission to use and publish the photographs/film/videotapes/electronic representations and/or sound recordings made of me or my child at all Scouting activities, and I hereby release the Boy Scouts of America, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with the activity from any and all liability from such use and publication. I further authorize the reproduction, sale, copyright, exhibit, broadcast, electronic storage, and/or distribution of said photographs/film/videotapes/electronic representations and/or sound recordings without limitation at the discretion of the BSA, and I specifically waive any right to any compensation I may have for any of the foregoing.



NOTE: Due to the nature of programs and activities, the Boy Scouts of America and local councils cannot continually monitor compliance of program participants or any limitations imposed upon them by parents or medical providers. However, so that leaders can be as familiar as possible with any limitations, list any restrictions imposed on a child participant in connection with programs or activities below.



List participant restrictions, if any: None

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. If I am participating at Philmont, Philmont Training Center, Northern Tier, Florida Sea Base, or the Summit Bechtel Reserve, I have also read and understand the supplemental risk advisories, including height and weight requirements and restrictions, and understand that the participant will not be allowed to participate in applicable high-adventure programs if those requirements are not met. The participant has permission to engage in all high-adventure activities described, except as specifically noted by me or the health-care provider. If the participant is under the age of 18, a parent or guardian's signature is required.

Participant's signature: _____ Date: _____

Parent/guardian signature for youth: _____ Date: _____

(If participant is under the age of 18)

Second parent/guardian signature for youth: _____ Date: _____

(If required; for example, California)

Complete this section for youth participants only:

Adults Authorized to Take to and From Events:

You must designate at least one adult. Please include a telephone number.

Name: _____

Name: _____

Telephone: _____

Telephone: _____

Adults NOT Authorized to Take Youth To and From Events:

Name: _____

Name: _____

Telephone: _____

Telephone: _____



Part B: General Information/Health History

Full name: _____

High-adventure base participants:

Expedition/crew No.: _____

or staff position: _____

DOB: _____

Age: _____ Gender: _____ Height (inches): _____ Weight (lbs.): _____

Address: _____

City: _____ State: _____ ZIP code: _____ Telephone: _____

Unit leader: _____ Mobile phone: _____

Council Name/No.: _____ Unit No.: _____

Health/Accident Insurance Company: _____ Policy No.: _____



Please attach a photocopy of both sides of the insurance card. If you do not have medical insurance, enter "none" above.



In case of emergency, notify the person below:

Name: _____ Relationship: _____

Address: _____ Home phone: _____ Other phone: _____

Alternate contact name: _____ Alternate's phone: _____

Health History

Do you currently have or have you ever been treated for any of the following?

Yes	No	Condition	Explain
		Diabetes	Last HbA1c percentage and date:
		Hypertension (high blood pressure)	
		Adult or congenital heart disease/heart attack/chest pain (angina)/heart murmur/coronary artery disease. Any heart surgery or procedure. Explain all "yes" answers.	
		Family history of heart disease or any sudden heart-related death of a family member before age 50.	
		Stroke/TIA	
		Asthma	Last attack date:
		Lung/respiratory disease	
		COPD	
		Ear/eyes/nose/sinus problems	
		Muscular/skeletal condition/muscle or bone issues	
		Head injury/concussion	
		Altitude sickness	
		Psychiatric/psychological or emotional difficulties	
		Behavioral/neurological disorders	
		Blood disorders/sickle cell disease	
		Fainting spells and dizziness	
		Kidney disease	
		Seizures	Last seizure date:
		Abdominal/stomach/digestive problems	
		Thyroid disease	
		Excessive fatigue	
		Obstructive sleep apnea/sleep disorders	CPAP: Yes <input type="checkbox"/> No <input type="checkbox"/>
		List all surgeries and hospitalizations	Last surgery date:
		List any other medical conditions not covered above	



Part B: General Information/Health History

Full name: _____
 DOB: _____

High-adventure base participants:
 Expedition/crew No.: _____
 or staff position: _____

Allergies/Medications

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

Yes	No	Allergies or Reactions	Explain	Yes	No	Allergies or Reactions	Explain
		Medication				Plants	
		Food				Insect bites/stings	

List all medications currently used, including any over-the-counter medications.

CHECK HERE IF NO MEDICATIONS ARE ROUTINELY TAKEN. IF ADDITIONAL SPACE IS NEEDED, PLEASE INDICATE ON A SEPARATE SHEET AND ATTACH.

Medication	Dose	Frequency	Reason

YES NO Non-prescription medication administration is authorized with these exceptions: _____

Administration of the above medications is approved for youth by:

_____/_____
 Parent/guardian signature MD/DO, NP, or PA signature (if your state requires signature)

!

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.

!

Immunization

The following immunizations are recommended by the BSA. Tetanus immunization is required and must have been received within the last 10 years. If you had the disease, check the disease column and list the date. If immunized, check yes and provide the year received.

Yes	No	Had Disease	Immunization	Date(s)	Please list any additional information about your medical history:
			Tetanus		
			Pertussis		
			Diphtheria		
			Measles/mumps/rubella		
			Polio		
			Chicken Pox		
			Hepatitis A		
			Hepatitis B		
			Meningitis		
			Influenza		
			Other (i.e., HIB)		
			Exemption to immunizations (form required)		

DO NOT WRITE IN THIS BOX
 Review for camp or special activity.

Reviewed by: _____

Date: _____

Further approval required: Yes No

Reason: _____

Approved by: _____

Date: _____

Part C: Pre-Participation Physical

Required for all participants of all full-week, sleep-away programs.

This part must be completed by certified and licensed physicians (MD, DO), nurse practitioners, or physician assistants.

Full name: _____

DOB: _____

High-adventure base participants:

Expedition/crew No.: _____

or staff position: _____

!

You are being asked to certify that this individual has no contraindication for participation inside a Scouting experience. For individuals who will be attending a high-adventure program, including one of the national high-adventure bases, please refer to the supplemental information on the following pages or the form provided by your patient.

!

Examiner: Please fill in the following information:

		Yes	No	Explain							
Medical restrictions to participate											
Yes	No	Allergies or Reactions		Explain		Yes	No	Allergies or Reactions		Explain	
		Medication						Plants			
		Food						Insect bites/stings			

Height (inches): _____ Weight (lbs.): _____ BMI: _____ Blood Pressure: _____ / _____ Pulse: _____

	Normal	Abnormal	Explain Abnormalities
Eyes			
Ears/nose/throat			
Lungs			
Heart			
Abdomen			
Genitalia/hernia			
Musculoskeletal			
Neurological			
Other			

Examiner's Certification

I certify that I have reviewed the health history and examined this person and find no contraindications for participation in a Scouting experience. This participant (with noted restrictions):

True	False	Explain
		Meets height/weight requirements.
		Does not have uncontrolled heart disease, asthma, or hypertension.
		Has not had an orthopedic injury, musculoskeletal problems, or orthopedic surgery in the last six months or possesses a letter of clearance from his or her orthopedic surgeon or treating physician.
		Has no uncontrolled psychiatric disorders.
		Has had no seizures in the last year.
		Does not have poorly controlled diabetes.
		If less than 18 years of age and planning to scuba dive, does not have diabetes, asthma, or seizures.
		For high-adventure participants, I have reviewed with them the important supplemental risk advisory provided.

Examiner's Signature: _____ Date: _____

Provider printed name: _____

Address: _____

City: _____ State: _____ ZIP code: _____

Office phone: _____

Height/Weight Restrictions

If you exceed the 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, you may not be allowed to participate.

Maximum weight for height:

Height (inches)	Max. Weight	Height (inches)	Max. Weight	Height (inches)	Max. Weight	Height (inches)	Max. Weight
60	166	65	195	70	226	75	260
61	172	66	201	71	233	76	267
62	178	67	207	72	239	77	274
63	183	68	214	73	246	78	281
64	189	69	220	74	252	79 and over	295



Part D: Treasure Valley Scout Reservation Supplement

Required for all youth participants of all programs.

Scout/Child's name : _____ Unit/Group : _____

DOB: _____ Camp Program/Week Attending: _____

Shooting Sports

Compliance to State Law : Authorized use of firearms by a minor.

The Mohegan Council adheres to all applicable laws and operates under the governance of BSA National Standards as well as MA State Health Code. As a part of the Boy Scout program the council operates several safe shooting sports ranges for scouts to participate in BB shooting (Cub Scouts), rifle shooting & shotgun (Boy Scouts), and archery (Cub Scouts and Boy Scouts). In order to meet the Mass General Laws Chapter 140 section 130 the Council requires parental permission to participate in such activities.

Mass General Laws Chapter 140, Section 130 stipulates the following:

Furnishing Child 15 or older with Rifle, Shotgun and Ammunition "Nothing in this section shall be construed to prohibit an instructor from furnishing rifles or shotguns or ammunition to pupils; provided however that said instructor has the consent of a parent or guardian of a pupil under the age of 18." The pupil must be under the direct supervision of a person (the range instructor) holding a valid Firearms Identification Card or a License to Carry Firearms.

I hereby AUTHORIZE my child, named above, to participate in all events during summer camp including (if age appropriate) use of the shooting sports program areas (for rifle and shotgun under supervision of an FID instructor).

I DO NOT AUTHORIZE my child, named above, to participate in shooting sports activities. However, my child is authorized to participate in all other events and activities of the camp.

Over the Counter Medications

The following over the counter medications will be available through the health officer if a Scout becomes ill during camp.

Please check the medications your child may be given if needed. Medicine will be administered per package instructions. Please send your child's own supply of over the counter medicine (in the original container) if they are a normal routine or taken daily.



NOTE: Failure to complete this section or to authorize any OTC Medication can result in a uncomfortable experience at camp. If you have any questions regarding administration of medications, please contact camp personnel.

Check all that are authorized:

<input type="checkbox"/> Acetaminophen (Tylenol)	<input type="checkbox"/> Pepto Bismol	<input type="checkbox"/> Bug Spray	<input type="checkbox"/> Sun Burn Cream (Aloe)
<input type="checkbox"/> Ibuprofen (Motrin)	<input type="checkbox"/> Decongestant	<input type="checkbox"/> After Bite	<input type="checkbox"/> Calamine Lotion
<input type="checkbox"/> Benadryl/Antihistamine	<input type="checkbox"/> Antacid	<input type="checkbox"/> Eye Drops	<input type="checkbox"/> Antibiotic Ointment
	<input type="checkbox"/> Anti-Diarrhea	<input type="checkbox"/> Swimmer's Ear	<input type="checkbox"/> Sun Block

Informed Consent & Release

I consent that the prior provided information is accurate and true. I acknowledge that I am allowing my Scout/Child to participate at summer camp entirely upon my own initiative, risk and responsibility.

I further, in consideration of the permission extended to my child to attend summer camp, do hereby for myself, my spouse, my child, my heirs, executors, and administrators, remiss, release, and forever discharge the Camp Administration, staff, and volunteers of Treasure Valley Scout Reservation, as well as the Mohegan Council, the Boy Scouts of America, its officers, members, as well as all other participants and sponsors of said summer camp, acting officially or otherwise, from all claims, demands, actions or causes of action of any kind including death of my child or any injury to my child or loss or damage to property which may occur from any cause during summer camp.

Parent/Guardian of Scout/Child signature: _____ Date: _____

