BOY SCOUTS OF AMERICA®
HEART OF NEW ENGLAND COUNCIL

2024 Summer Camp Medical Form Instructions

BSA standards and state laws require accurate medical records for campers and staff. They are also critical to ensure timely, effective care should you or your Scout become sick or injured while at camp. All campers, adult leaders and staff MUST complete the BSA Annual Health and Medical Record form annually. Forms expire after the last day of the 12th calendar month from the physical exam date (similar to car inspection stickers).

Without a completed medical form, Scouts, leaders, parents, and visitors WILL NOT PARTICIPATE in many camp activities including (but not limited to) swimming, boating, climbing, COPE, and sports, and may not remain in camp longer than 72 hours.

Read the medical form carefully. The next page highlights areas that are commonly incomplete. Please note the following:

Part A

This page contains an important risk advisory, informed consent, and release. Please read this advisory carefully. The participant and parents (if participant is under 18) must sign to acknowledge agreement with the information on this page. This page also includes space to list adults who are authorized (or prohibited) to take this participant to/from events.

Part B

Part B contains the participant's contact and insurance information and general health history. Page 2 of this section contains information about medication and allergies. Please complete these sections carefully and accurately. The parents and health care professional must sign to authorize all medication **including non-prescription medication.**

Part C

Part C is the annual physical. This page should be completed and signed by the health care professional conducting the physical examination. If your health care professional generates a form for their office that is used for sports, schools, or camp that includes an e-Signature, everything listed on Part C, and clears the participant to participate in activities without restrictions, attach it to the medical form - the physician does NOT have to sign part C in this case. Physicals are required for all events lasting longer than 72 hours.

Part D-NH

Part D-NH is unique to Camp Wanocksett. This page provides permission to possess & use epinephrine auto-injectors and/or asthma inhalers. The Scout's health care professional and the parent/guardian must sign the bottom of this page. This Is required by NH state regulations; this page is not required for Scouts attending any camps in Massachusetts.

Part D-MA

Part D-MA is unique to Treasure Valley and HNE's Cub Scout Day Camp Programs. This page includes authorizations for Scouts to participate in Shooting Sports activities during summer camp as well as be provided with specific over-the-counter medications. A parent/guardian must sign the bottom of this page. These items are required by MA state regulations; this page is not required for Scouts attending Camp Wanocksett.

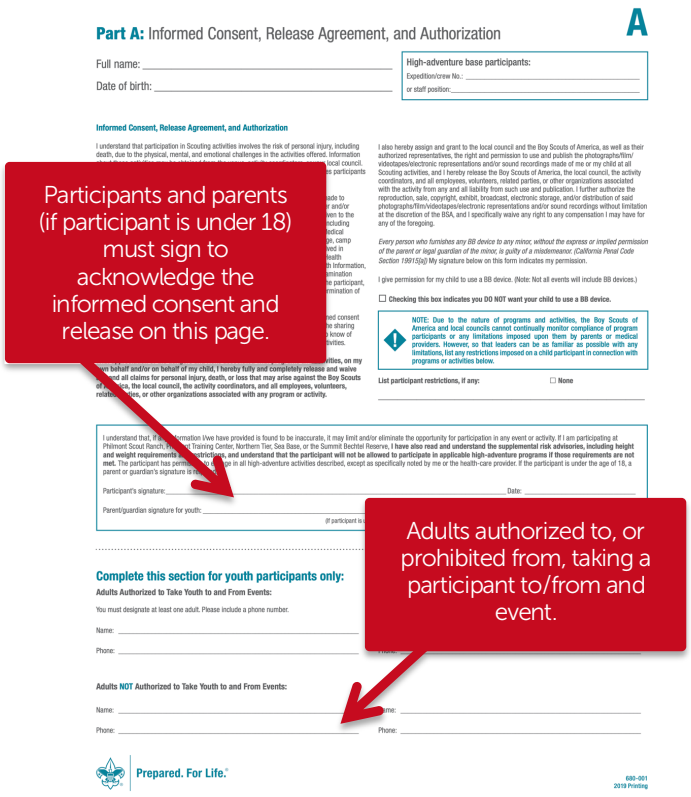
Common Mistakes

- Missing parent/guardian signature (Part A)
- Missing emergency contact information (Part B)
- Incomplete medication information (Part B)
- Missing signature for non-prescription medication (Part B)
- Missing medical insurance card (Part B)
- Missing complete immunization record (Part B)
- Missing physician signature (Part B & C)
- Physical exam more than 12 months ago (Part C)

NOTE: NH State regulations require that a copy of your complete immunization record be attached to your medical form. MA State regulations require written documentation showing immunizations are up to date in accordance with the most current CDC Immunization Schedules.

Only submit a **COPY** of your medical form. Keep the original for use at other Scouting activities.

Part A



Part A: Informed Consent, Release Agreement, and Authorization

A

Full name: _____

Date of birth: _____

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 the activities of 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.

Every person who furnishes any BB device to any minor, without the express or implied permission of the parent or legal guardian of the minor, is guilty of a misdemeanor. (California Penal Code Section 19915(a)) My signature below on this form indicates my permission.

I give permission for my child to use a BB device. (Note: Not all events will include BB devices.)

☐ Checking this box indicates you DO NOT want your child to use a BB device.

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 Scout Ranch, [illegible] Training Center, Northern Tier, 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: _____

(If participant is [illegible])

Complete this section for youth participants only:

Adults Authorized to Take Youth to and From Events:

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

Name: _____

Phone: _____

Adults NOT Authorized to Take Youth to and From Events:

Name: _____ Name: _____

Phone: _____ Phone: _____

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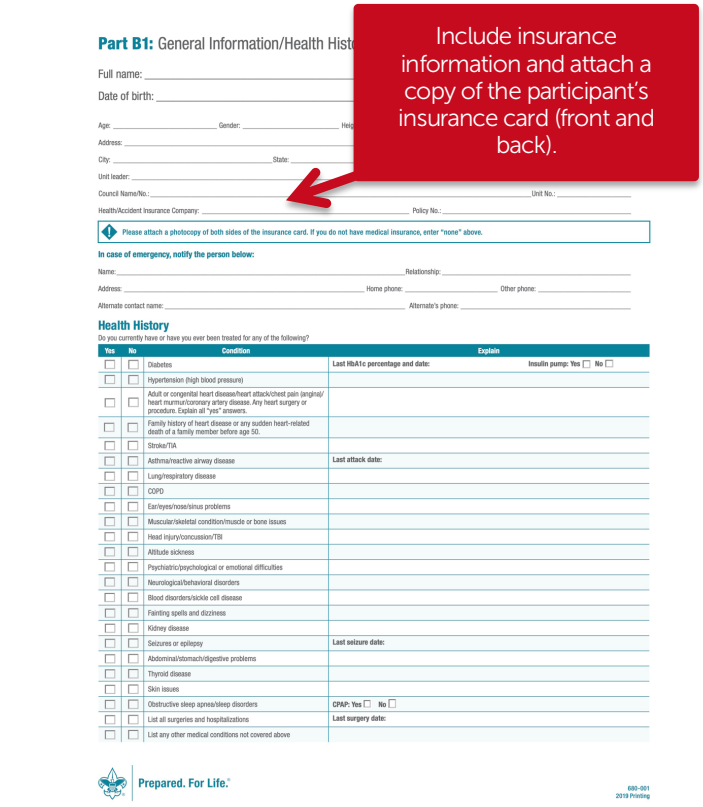
Participants and parents (if participant is under 18) must sign to acknowledge the informed consent and release on this page.

Adults authorized to, or prohibited from, taking a participant to/from and event.

Part B1



Part B1: General Information/Health Hist

Full name: _____

Date of birth: _____

Age: _____ Gender: _____ Hei

Address: _____

City: _____ State: _____

Unit leader: _____

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: Insulin pump: Yes ☐ No ☐
☐	☐	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/reactive airway disease	Last attack date:
☐	☐	Lung/respiratory disease	
☐	☐	COPD	
☐	☐	Ear/eyes/nose/sinus problems	
☐	☐	Muscular/skeletal condition/muscle or bone issues	
☐	☐	Head injury/concussion/TBI	
☐	☐	Altitude sickness	
☐	☐	Psychiatric/psychological or emotional difficulties	
☐	☐	Neurological/behavioral disorders	
☐	☐	Blood disorders/sickle cell disease	
☐	☐	Fainting spells and dizziness	
☐	☐	Kidney disease	
☐	☐	Seizures or epilepsy	Last seizure date:
☐	☐	Abdominal/stomach/digestive problems	
☐	☐	Thyroid disease	
☐	☐	Skin issues	
☐	☐	Obstructive sleep apnea/sleep disorders	CPAP: Yes ☐ No ☐
☐	☐	List all surgeries and hospitalizations	Last surgery date:
☐	☐	List any other medical conditions not covered above	

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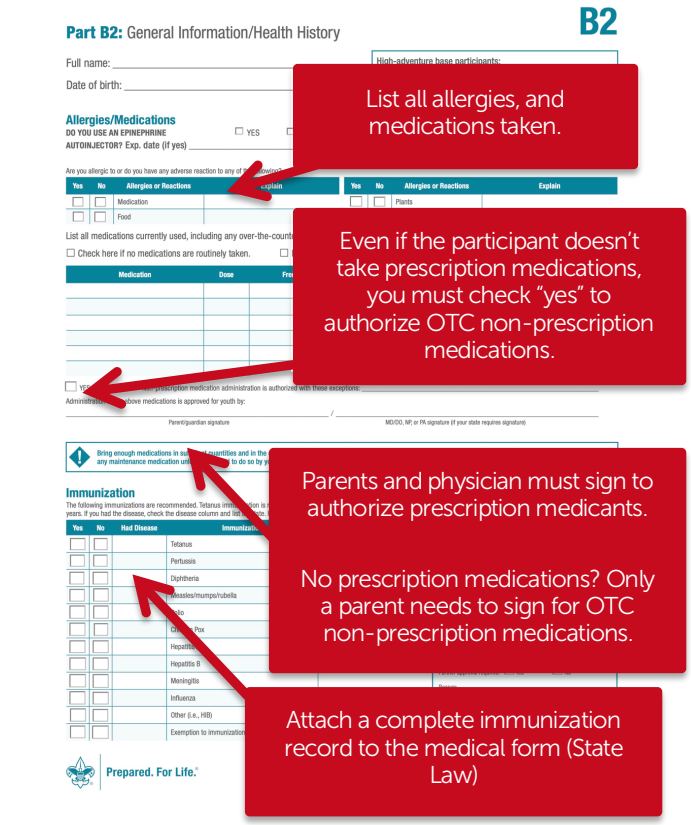
Include insurance information and attach a copy of the participant's insurance card (front and back).

Part B2



Part B2: General Information/Health History

B2

Full name: _____

Date of birth: _____

High-adventure base participants:

Allergies/Medications

DO YOU USE AN EPINEPHRINE AUTOINJECTOR? Exp. date (if yes) _____ ☐ YES

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					

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

☐ Check here if no medications are routinely taken.

Medication	Dose	Fre

☐ YES ☐ [illegible] prescription medication administration is authorized with these exceptions: _____

Administration of 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 su[illegible] countries and in the original packaging with any maintenance medication unt[illegible] to do so by y[illegible]

Immunization

The following immunizations are recommended. Tetanus immu[illegible] years. If you had the disease, check the disease column and not

Yes	No	Had Disease	Immunizati[illegible]
☐	☐		Tetanus
☐	☐		Pertussis
☐	☐		Diphtheria
☐	☐		Measles/mumps/rubella
☐	☐		Polio
☐	☐		Chicken Pox
☐	☐		Hepatitis A
☐	☐		Hepatitis B
☐	☐		Meningitis
☐	☐		Influenza
☐	☐		Other (i.e., HIB)
☐	☐		Exemption to immunization

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List all allergies, and medications taken.

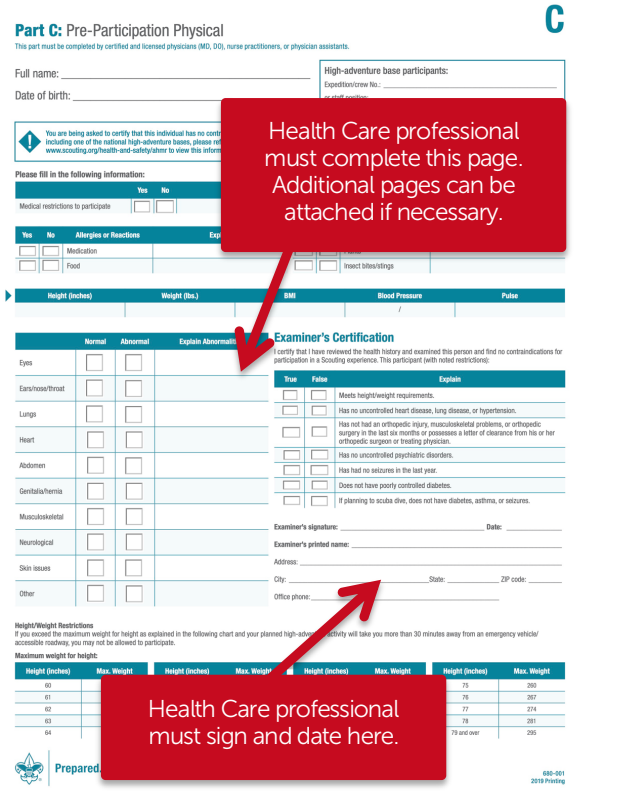
Even if the participant doesn't take prescription medications, you must check "yes" to authorize OTC non-prescription medications.

Parents and physician must sign to authorize prescription medicants.

No prescription medications? Only a parent needs to sign for OTC non-prescription medications.

Attach a complete immunization record to the medical form (State Law)

Part C



Part C: Pre-Participation Physical

C

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

Full name: _____

Date of birth: _____

High-adventure base participants:

Expedition/crew No.: _____

You are being asked to certify that this individual has no certi[illegible] including one of the national high-adventure bases, please re[illegible] www.scouting.org/health-and-safety/ahmr to view this inform[illegible]

Please fill in the following information:

	Yes	No
Medical restrictions to participate	☐	☐

Yes	No	Allergies or Reactions	Exp[illegible]			
☐	☐	Medication		☐	☐	Insect bites/stings
☐	☐	Food				

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

	Normal	Abnormal	Explain Abnormalit[illegible]
Eyes	☐	☐	
Ears/nose/throat	☐	☐	
Lungs	☐	☐	
Heart	☐	☐	
Abdomen	☐	☐	
Genitalia/hernia	☐	☐	
Musculoskeletal	☐	☐	
Neurological	☐	☐	
Skin issues	☐	☐	
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.
☐	☐	Has no uncontrolled heart disease, lung disease, 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 planning to scuba dive, does not have diabetes, asthma, or seizures.

Examiner's signature: _____ Date: _____

Examiner's 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-adve[illegible] 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						75	260
61						76	267
62						77	274
63						78	281
64						79 and over	295

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Health Care professional must complete this page. Additional pages can be attached if necessary.

Health Care professional must sign and date here.

Part A: Informed Consent, Release Agreement, and Authorization

A

Full name: _____

Date of birth: _____

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.

Every person who furnishes any BB device to any minor, without the express or implied permission of the parent or legal guardian of the minor, is guilty of a misdemeanor. (California Penal Code Section 19915[a]) My signature below on this form indicates my permission.

I give permission for my child to use a BB device. (Note: Not all events will include BB devices.)

☐ **Checking this box indicates you DO NOT want your child to use a BB device.**

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 Scout Ranch, Philmont Training Center, Northern Tier, 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)

Complete this section for youth participants only:

Adults Authorized to Take Youth to and From Events:

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

Name: _____ Name: _____

Phone: _____ Phone: _____

Adults NOT Authorized to Take Youth to and From Events:

Name: _____ Name: _____

Phone: _____ Phone: _____

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Part B1: General Information/Health History

B1

Full name: _____

Date of birth: _____

High-adventure base participants:

Expedition/crew No.: _____

or staff position: _____

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

Address: _____

City: _____ State: _____ ZIP code: _____ Phone: _____

Unit leader: _____ Unit leader's mobile #: _____

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:** **Insulin pump: Yes** ☐ **No** ☐
☐	☐	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/reactive airway disease	**Last attack date:**
☐	☐	Lung/respiratory disease	
☐	☐	COPD	
☐	☐	Ear/eyes/nose/sinus problems	
☐	☐	Muscular/skeletal condition/muscle or bone issues	
☐	☐	Head injury/concussion/TBI	
☐	☐	Altitude sickness	
☐	☐	Psychiatric/psychological or emotional difficulties	
☐	☐	Neurological/behavioral disorders	
☐	☐	Blood disorders/sickle cell disease	
☐	☐	Fainting spells and dizziness	
☐	☐	Kidney disease	
☐	☐	Seizures or epilepsy	**Last seizure date:**
☐	☐	Abdominal/stomach/digestive problems	
☐	☐	Thyroid disease	
☐	☐	Skin issues	
☐	☐	Obstructive sleep apnea/sleep disorders	**CPAP: Yes** ☐ **No** ☐
☐	☐	List all surgeries and hospitalizations	**Last surgery date:**
☐	☐	List any other medical conditions not covered above	

Part B2: General Information/Health History

B2

Full name: _____

Date of birth: _____

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

Allergies/Medications

DO YOU USE AN EPINEPHRINE AUTOINJECTOR? ☐ YES ☐ NO Exp. date (if yes) _____

DO YOU USE AN ASTHMA RESCUE INHALER? ☐ YES ☐ NO Exp. date (if yes) _____

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

Yes	No	Allergies or Reactions	Explain
☐	☐	Medication	
☐	☐	Food	

Yes	No	Allergies or Reactions	Explain
☐	☐	Plants	
☐	☐	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 list 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. 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)
☐	☐		Tetanus	
☐	☐		Pertussis	
☐	☐		Diphtheria	
☐	☐		Measles/mumps/rubella	
☐	☐		Polio	
☐	☐		Chicken Pox	
☐	☐		Hepatitis A	
☐	☐		Hepatitis B	
☐	☐		Meningitis	
☐	☐		Influenza	
☐	☐		Other (i.e., HIB)	
☐	☐		Exemption to immunizations **(form required)**	

Please list any additional information about your medical history:

_____

_____

_____

_____

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

Reviewed by: _____

Date: _____

Further approval required: ☐ Yes ☐ No

Reason: _____

Approved by: _____

Date: _____

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Part C: Pre-Participation Physical

C

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

Full name: _____

Date of birth: _____

High-adventure base participants:

Expedition/crew No.: _____

or staff position: _____

You are being asked to certify that this individual has no contraindication for participation in 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. You can also visit www.scouting.org/health-and-safety/ahmr to view this information online.

Please fill in the following information:

	Yes	No	Explain
Medical restrictions to participate	☐	☐	

Yes	No	Allergies or Reactions	Explain
☐	☐	Medication	
☐	☐	Food	

Yes	No	Allergies or Reactions	Explain
☐	☐	Plants	
☐	☐	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	☐	☐	
Skin issues	☐	☐	
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.
☐	☐	Has no uncontrolled heart disease, lung disease, 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 planning to scuba dive, does not have diabetes, asthma, or seizures.

Examiner's signature: _____ **Date:** _____

Examiner's 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

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HEART OF NEW ENGLAND COUNCIL

Part D-NH: Permission to Possess & Use Epinephrine Auto-Injector and/or Asthma Inhaler

Pursuant to NH RSA 485-A:25-a-g, this form must be completed in its entirety and signed by a parent/guardian AND physician in order for your child to carry an auto-injector and/or asthma inhaler with him/her while at camp.

Physician's Section

Camper's Name:	
Diagnosis requiring Epinephrine Auto-injector/Asthma Inhaler:	
Are there any other medical conditions? Yes ☐ No ☐ If Yes, please explain:	
Name/Dose/route of medication:	Date of Order:
Does the camper need assistance with administration of medication? Yes ☐ No ☐ If Yes, please explain:	
Specific recommendations for administration (what symptoms would indicate need for administration of this medication?)	
List any special side effects, contraindications and/or adverse reactions to be observed if the medication is administered:	
List any adverse reactions that may occur to another child, for whom the above medication is not prescribed, should he or she receive a dose of the medication:	

As the child's physician, I give permission for this child to possess and use ☐ Epinephrine auto-injector ☐ Asthma Inhaler. This child has the knowledge and skills to safely possess and use the identified medication in a camp setting	
Physician's Signature:	Date
Physician's Name (printed):	
Physician's Business Phone:	Emergency Phone:
Physician's Address:	

Parent/Guardian's Section

I hereby give permission for the camper named above to keep the above-named medication in his/her possession while attending a Heart of New England Council Summer Camp. I will also provide a second auto-injector and/or asthma inhaler that, **by law**, must be kept at the health lodge for emergencies.

Parent/Guardian Signature:	Date:

BOY SCOUTS OF AMERICA®
HEART OF NEW ENGLAND COUNCIL

Part D-MA: Supplement *Required for all youth participants of all programs at Camp Split Rock and Treasure Valley*

Camper's Name: **DOB**:

Shooting Sports - Compliance to State Law : Authorized use of firearms by a minor

The Heart of New England 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 BSA program, the council operates several safe shooting sports ranges for Scouts to participate in BB shooting (Cub Scouts, BSA), rifle shooting & shotgun (Scouts, BSA & Venturing, BSA), and archery (All Programs). In order to meet the Mass General Laws Chapter 140 section 130 the Council requires parental permission to participate in such activities.

MA General Laws Chapter 140, Section 130 ½ "Lawfully furnishing weapons to minors for hunting, recreation, instruction and participation in shooting sports" stipulates the following:

> *"Notwithstanding section 130 or any general or special law to the contrary, it shall be lawful to furnish a weapon to a minor for hunting, recreation, instruction and participation in shooting sports while under the supervision of a holder of a valid firearm identification card or license to carry appropriate for the weapon in use; provided, however, that the parent or guardian of the minor granted consent for such activities."*

☐ **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 an uncomfortable experience at camp. If you have any questions regarding administration of medications, please contact camp personnel.

Check all that are authorized:

☐ Acetaminophen (Tylenol)	☐ Pepto Bismol	☐ Bug Spray	☐ Sub Burn Cream (Aloe)
☐ Ibuprofen (Motrin)	☐ Decongestant	☐ After Bite	☐ Calamine Lotion
☐ Benadryl/Antihistamine	☐ Antacid	☐ Eye Drops	☐ Antibiotic Ointment
☐ Anti-Diarrhea	☐ Swimmer's Ear	☐ Sun Block	

Parent/Guardian's Signature: Date:

Authorization to Administer Medication to a Camper

(completed by parent/guardian)

**** Newly required Summer Camp 2018 *****

Per State of Massachusetts – Department of Public Health

- *All medications brought to camp, including over the counter, epinephrine injectors and inhalers must be included on this authorization. See* ***Advisory regarding the Parent/Guardian Authorization to Administer Medication to a Camper.***

  https://www.mass.gov/lists/recreational-camps-for-children-community-sanitation

- ***All medications must be in original prescription or retail container. All medication must be given by the health supervisor/nurse. This form must be filled completely.***

- ***If more than 4 medications are being brought to camp, please use additional copies of the Authorization to Administer Medications to a Camper packet.***

- ***Please make sure that if any prescriptions are added or changed for the first day of camp – that you have updated this form to include those changes.***

- ***We regret any inconvenience that these new State mandated regulations may have and thank you for ensuring we are in full compliance with all applicable State regulations.***

Camper and Parent/Guardian Information	
Camper's Name:	Pack/Troop/Unit #:
Age:	Food/Drug Allergies:
Diagnosis (at parent/guardian discretion):	
Parent/Guardian's Name:	
Home Phone:	Business Phone:
Emergency Telephone:	

Licensed Prescriber Information	
Name of Licensed Prescriber:	
Business Phone:	Emergency Phone:

Medication Information 1	
Name of Medication:	
Dose given at camp:	Route of Administration:
Frequency:	Date Ordered:
Duration of Order:	Quantity Received:
Expiration date of Medication Received:	
Special Storage Requirements:	
Special Directions (e.g., on empty stomach/with water):	
Special Precautions:	
Possible Side Effects/Adverse Reactions:	
Other medications (at parent/guardian discretion):	
Location where medication administration will occur: *Appropriate TVSR Med Office*	

Medication Information 2	
Name of Medication:	
Dose given at camp:	Route of Administration:
Frequency:	Date Ordered:
Duration of Order:	Quantity Received:
Expiration date of Medication Received:	
Special Storage Requirements:	
Special Directions (e.g., on empty stomach/with water):	
Special Precautions:	
Possible Side Effects/Adverse Reactions:	
Other medications (at parent/guardian discretion):	
Location where medication administration will occur: *Appropriate TVSR Med Office*	

Medication Information 3	
Name of Medication:	
Dose given at camp:	Route of Administration:
Frequency:	Date Ordered:
Duration of Order:	Quantity Received:
Expiration date of Medication Received:	
Special Storage Requirements:	
Special Directions (e.g., on empty stomach/with water):	
Special Precautions:	
Possible Side Effects/Adverse Reactions:	
Other medications (at parent/guardian discretion):	
Location where medication administration will occur: *Appropriate TVSR Med Office*	

Medication Information 4	
Name of Medication:	
Dose given at camp:	Route of Administration:
Frequency:	Date Ordered:
Duration of Order:	Quantity Received:
Expiration date of Medication Received:	
Special Storage Requirements:	
Special Directions (e.g., on empty stomach/with water):	
Special Precautions:	
Possible Side Effects/Adverse Reactions:	
Other medications (at parent/guardian discretion):	
Location where medication administration will occur: *Appropriate TVSR Med Office*	

Authorization Information

I hereby authorize the health care consultant or properly trained health care supervisor at ***Treasure Valley Scout Reservation***
(name of camp)
to administer, to my child, _____ the medication(s) listed above, in accordance with 105 CMR
(name of camper)
430.160(C) and 105 CMR 430.160(D) [see below].

If above listed medication includes epinephrine injection system:

I hereby authorize my child to self-administer , with approval of the health care consultant ☐ Yes ☐ No ☐ Not Applicable

I hereby authorize an employee that has received training in allergy awareness and epinephrine administration to administer

☑ Yes ☐ No ☐ Not Applicable

If above listed medication includes insulin for diabetic management:

I hereby authorize my child to self-administer , with approval of the health care consultant ☐ Yes ☐ No ☐ Not Applicable

Signature of Parent/Guardian:	Date:

** **Health Care Consultant** at a recreational camp is a Massachusetts licensed physician, certified nurse practitioner, or a physician assistant with documented pediatric training. **Health Care Supervisor** is a staff person of a recreational camp for children who is 18 years old or older; is responsible for the day to day operation of the health program or component, and is a Massachusetts licensed physician, physician assistant, certified nurse practitioner, registered nurse, licensed practical nurse, or other person specially trained in first aid.

105 CMR 430 References

105 CMR 430.160(A): Medication prescribed for campers shall be kept in original containers bearing the pharmacy label, which shows the date of filling, the pharmacy name and address, the filling pharmacist's initials, the serial number of the prescription, the name of the patient, the name of the prescribing practitioner, the name of the prescribed medication, directions for use and cautionary statements, if any, contained in such prescription or required by law, and if tablets or capsules, the number in the container. All over the counter medications for campers shall be kept in the original containers containing the original label, which shall include the directions for use. **(M.G.L. c. 94C § 21).**

105 CMR 430.160(C): Medication shall only be administered by the health care supervisor or by a licensed health care professional authorized to administer prescription medications. If the health care supervisor is not a licensed health care professional authorized to administer prescription medications, the administration of medications shall be under the professional oversight of the health care consultant. The health care consultant shall acknowledge in writing a list of all medications administered at the camp. Medication prescribed for campers brought from home shall only be administered if it is from the original container, and there is written permission from the parent/guardian.

105 CMR 430.160(D): A written policy for the administration of medications at the camp shall identify the individuals who will administer medications. This policy shall:

(1) List individuals at the camp authorized by scope of practice (such as licensed nurses) to administer medications; and/or other individuals qualified as health care supervisors who are properly trained or instructed, and designated to administer oral or topical medications by the health care consultant.

(2) Require health care supervisors designated to administer prescription medications to be trained or instructed by the health care consultant to administer oral or topical medications.

(3) Document the circumstances in which a camper, Heath Care Supervisor, or Other Employee may administer epinephrine injections. A camper prescribed an epinephrine auto-injector for a known allergy or pre-existing medical condition may:

a) Self-administer and carry an epinephrine auto-injector with him or her at all times for the purposes of self-administration if:

1) the camper is capable of self-administration; and

2) the health care consultant and camper's parent/guardian have given written approval

(b) Receive an epinephrine auto-injection by someone other than the Health Care Consultant or person who may give injections within their scope of practice if:

1) the health care consultant and camper's parent/guardian have given written approval; and

2) the health care supervisor or employee has completed a training developed by the camp's health care consultant in accordance with the requirements in 105 CMR 430.160.

(4) Document the circumstances in which a camper may self-administer insulin injections. If a diabetic child requires his or her blood sugar be monitored, or requires insulin injections, and the parent or guardian and the camp health care consultant give written approval, the camper, who is capable, may be allowed to self-monitor and/or self-inject himself or herself. Blood monitoring activities such as insulin pump calibration, etc. and self-injection must take place in the presence of the properly trained health care supervisor who may support the child's process of self-administration.

105 CMR 430.160(F): The camp shall dispose of any hypodermic needles and syringes or any other medical waste in accordance with 105 CMR 480.000: Minimum Requirements for the Management of Medical or Biological Waste.

105 CMR 430.160(I): When no longer needed, medications shall be returned to a parent or guardian whenever possible. If the medication cannot be returned, it shall be disposed of as follows:

(1) Prescription medication shall be properly disposed of in accordance with state and federal laws and such disposal shall be documented in writing in a medication disposal log.

(2) The medication disposal log shall be maintained for at least three years following the date of the last entry.