Housatonic Council Presents

DAY CAMP 2025

Warsaw Park

119 Pulaski Hwy, Ansonia, CT 06401

housatonicscouting.org

WELCOME TO
CUB SCOUT DAY CAMP

Cub Scout Day Camp is an action packed week of adventures where Cub Scouts (grades K-5) can have fun while learning new skills. Running Monday through Friday, our camp offers a variety of hands-on activities to build confidence, teamwork, and a love for the outdoors. We will be doing our best to ensure every Cub leaves with new experiences and great memories!

CUB DAY CAMP WEEK 1
8/4 - 8/8

CUB DAY CAMP WEEK 2
8/11 - 8/15

DROP-OFF/CHECK-IN WILL TAKE PLACE AT THE WHITE TENT:

Monday	8:00 - 9:00 AM
Tuesday - Friday	8:30 - 9:00 AM

PICK-UP FOR SCOUTS AT FRONT DESK:

Monday - Friday	4:00 - 4:30 PM

PARENTS MUST SIGN OUT THEIR SCOUTS!
ALL VISITORS MUST SIGN IN AND OUT AT CAMP HEADQUARTERS

Cub Campers participate in a rotating variety of activities, some of the crazy adventures include:

Archery & BB gun shooting
STEM projects
Nature exploration
Crafts & woodworking
Sports & games
Scout skills

Day Camp helps Scouts earn advancements, make friends, and build confidence in a fun, safe environment!

EVERYTHING TO KNOW

SAFETY IS OUR TOP PRIORITY

Our camps are staffed daily by a certified health officer. Cub Scout Day Camp meets or exceeds National Scouting America Camp Standards and Complies with Connecticut State Law for youth camps.

All cub scouts and adult volunteers are required to submit their medical form prior to the start of camp. MAKE COPIES!!! Health forms will not be returned, per state law. No medical examinations can be given at camp.

All medications for scouts and adults needed while at camp must be turned into the health officer during check-in. Each form of medication must have a date as well as a doctor's name on the container. Medications must be in the original container with an attached photo! Non-prescription medication must be left with the health officer also. This is a state law.

Insurance: Housatonic Council provides secondary health and accident insurance for participants, which covers costs not paid by the primary carrier. Non-Housatonic Council participants need to provide proof of council/ unit insurance.

****Medications must be picked up prior to leaving camp at the end of the week. All medications left behind are destroyed two weeks after the end of camp.**

MAKE SURE TO BRING LUNCH!

We ask that scouts bring a fulfilling lunch to have during the day to keep them energized to have fun all day!

THE TRADING POST

Camp Trading Post: The camp trading post will be open each day offering a variety of snacks, treats, scout items, and small toys for purchase.

CAMP FEES REGISTRATION OPEN NOW!

CUB SCOUT DAY CAMP

Join us for a week of adventure! Get creative with arts & crafts, learn Scout skills, test your aim in archery, and have a blast with sports and games. Adventure On!

CUB DAY CAMP WEEK #1 8/4 - 8/8	CUB DAY CAMP WEEK #2 8/11 - 8/15
Cub Scout Day Camp Early Bird/Regular Fee $225 / $250	Additional Scout Week / Sibling Fee $175

CUB SCOUT RESIDENT CAMP

Cub Scouts can immerse themselves within the scouting program by attending a week of Resident Camp at Edmund D. Strang Scout Reservation! Come join us up at summer camp where you can stay in canvas tents, be part of our summer camp program, and join us on fun adventures!

CUB 3-DAY EXPERIENCE 7/13 - 7/16	CUB 6-DAY EXPERIENCE 7/20 - 7/26
3-Day Cub Residential Early Bird/Regular Fee $300 / $325	6-Day Cub Residential Early Bird/Regular Fee $425 / $450

HOUSATONIC COUNCIL DAY CAMP IS A NATIONALLY ACCREDITED CUB SCOUT AND WEBELOS DAY CAMP OPERATED BY THE HOUSATONIC COUNCIL, SCOUTING AMERICA

CONTACT:
203.734.3329
www.housatonicscouting.org

CUB SCOUT DAY CAMP REGISTRATION FORM

Parent Last Name: _____ Parent First Name: _____

Address: _____

Town / City: _____ State: _____ Zip: _____

Phone: _____ Pack #: _____ Scout Rank as of Sept. 2024: _____

Parents Signature (Required): _____

Parents Email: _____

CHECK THE APPROPRIATE WEEK(S) YOU WILL ATTEND AND CIRCLE THE FEE AMOUNT(S) PER YOUR PAYMENT DATE. Camp fee includes $85 non-refundable deposit.

AVAILABLE WEEKS OF CAMP

Cub Scout Camp Dates	Regular Fee After April 1st	Early Bird Fee Prior to April 1st	Additional Week / Sibling Fee
Week 1 Cub Scout Day Camp Monday, August 4th - Friday, August 8th	*$250*	*$225*	*$175*
Week 2 Cub Scout Day Camp Monday, August 11th - Friday, August 15th	*$250*	*$225*	*$175*
Residential Cub 3-Day Experience July 13th - July 16th	*$325*	*$300*	*$275*
Residential Cub 6-Day Experience July 20th - July 26th	*$450*	*$425*	*$400*

DISCOUNTS: Scouts attending 2 weeks of camp will receive a $100 Discount and families sending multiple youth receive a $50 discount per week.

PAYMENT INFORMATION

Payment by (check all that apply): Cash ___ or Check ___ or Credit Card Payment ___

Credit Card Type: MC ___ VISA ___ Date: _____ Check #: _____

Print Name of Card Holder: _____ Signature: _____

Credit Card #: _____ Security # on Back: ____ Expiration Date: _____

Remit to: Housatonic Council, Scouting America, 111 New Haven Ave, Derby, CT 06418 See refund request form for refund policy. ALL REFUND REQUEST MUST BE MADE IN WRITING TO THE COUNCIL SERVICE CENTER BY AUGUST 31st

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Phone: 203.734.3329

https://www.housatonicscouting.org

Housatonic Council, Scouting America Office
111 New Haven Avenue, Derby, CT 06418

The Edmund D. Strang Scout Reservation
278 Westside Road, Goshen, CT 06756

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REQUEST FOR REFUND

HOUSATONIC COUNCIL, SCOUTING AMERICA

All requests must be received by August 31st and must have the Pack Leaders approval (signature) to be considered for refund. If a Scout will be missing days during a camp period, that Scout needs to notify the Camp Director at check-in time. Refunds will NOT include the non-refundable $85.00 deposit.

Only circumstances under which refunds will be granted are as follows:

1. Illness of Scouts prevents their attendance at camp.
2. Illness or death in campers' immediate family prevents attendance at camp
3. Family relocation making attending camp impractical.
4. Mandatory attendance at summer school that is verifiable.
5. A scout leaves camp for medical reasons (home sickness is not considered a refundable medicinal reason) must be certified by the Camp Health Officer or Camp Director.

In such cases, the Scout will receive a pro-rated refund for the unused portion of the camp fee. If the unused portion constitutes three or more days and the medical excuse is not due to horseplay or negligence of said Scout.

NO REFUNDS WILL BE GRANTED FOR "NO SHOWS" OR DAYS MISSED

Scout's Name: _____ Troop / Pack #: _____

Address: _____

Town / City: _____ State: _____ Zip: _____

Parent's Name: _____ Phone: _____

Camp Attending and Date(s): _____

Reason for Refund: _____

_____

_____

_____

Amount Paid for Camp: $_____ Amount Requesting: $_____

Date paid for Camp: _____

Scoutmaster / Cubmaster's Signature (required): _____

INCOMPLETE REQUESTS WILL NOT BE PROCESSED

Mail to: ***Housatonic Council, Scouting America, 111 New Haven Avenue, Derby, CT 06418***

Phone: 203.734.3329

https://www.housatonicscouting.org

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CAMP SCHOLARSHIP APPLICATION

*A **$85 NON-REFUNDABLE DEPOSIT** is required to process application along with the Pack Leader's signature*

Name: _____ Age (as of 8/1/2025): _____

Address: _____

Town / City: _____ State: _____ Zip: _____

Email: _____

Phone: _____ Unit #: _____ Unit's Town: _____

Parent, briefly explain your need for Campership assistance: _____

_____

_____

My child is planning on attending _____ week(s) of camp.

Applying for:

- □ July 13 - July 16 — Week 1 - Cub Residential Camp Experience
- □ July 20 - July 26 — Week 2 - Cub Residential Camp Experience
- □ August 4th - August 8th — Week 1 Cub Scout Day Camp
- □ August 11th - August 15th — Week 2 Cub Scout Day Camp

I can afford $_____ toward my child's week(s) of camp.

The Unit will be contributing $_____ towards my child's week(s) at camp.

Number of people in the household: _____ Gross Income: _____

COPY OF THE FRONT PAGE OF MOST RECENT FORM 1040 REQUIRED

I understand that this is an application, and in no way guarantees a camp scholarship. I further understand that Housatonic Council awards partial camp scholarship and that Scouts are encouraged to earn part of their camp fee. This campership program is limited to use at Housatonic Council Camp facilities only.

Parents Name *(please print)*: _____

Address: _____ Town / City: _____ State: _____ Zip: _____

Parents Signature: _____ Email: _____

Mail to: ***Housatonic Council, Scouting America, 111 New Haven Avenue, Derby, CT 06418***

This applicant is a registered Scout within my unit:

Unit Leader's Signature: _____ Date: _____

APPLICATIONS MUST BE FILLED OUT COMPLETELY
INCOMPLETE APPLICATIONS WILL BE AUTOMATICALLY REJECTED

Phone: 203.734.3329

https://www.housatonicscouting.org

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111 New Haven Avenue, Derby, CT 06418

The Edmund D. Strang Scout Reservation
278 Westside Road, Goshen, CT 06756

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REQUIRED MEDICAL FORMS

All troops/packs send in medical forms with their Scoutmaster a week prior, during the Pre-Camp Meeting. All Scouts and Scouters must have a completed medical form to spend the week in camp. a Scout's health history must be filled out and signed by the parent/guardian within the past year and the medication signature must be within 90 days. The Camp Health Officer will check and collect all forms not previously turned in, as well as medications during check-in.

PLEASE SUBMIT A PHOTOCOPIED HEALTH FORM

Scouts not meeting the medical examination requirements will not be permitted to remain in camp. This pertains to all participating Scouts and leaders, no matter how long their stay in camp may be, ***including temporary leadership****.*

EACH MEDICATION TO BE ADMINISTERED BY THE HEALTH OFFICER WILL NEED:

- "Authorization for the Administration of Medication by School, Child Care, and Youth Camp Personnel" - page 24
- The doctor needs to fill out a form for each medication to be administered, including any over-the-counter, vitamins, inhalers, and EpiPens
- If the "Authorization for the Administration of Medication by School, Child Care, and Youth Camp Personnel" is not complete - the medication cannot be administered at Camp.

NO MEDICAL EXAMINATIONS CAN BE GIVEN AT CAMP!

MEDICATIONS

All medications for Scouts and Scouters must be turned into the Health Officer during check-in. The Health Officer will be located at the medical check-in station at the Health Lodge. All medications must have a ***photo of the camper*** *attached. Each form of medication must have a date as well as a doctor's name on the container.*

Medications must be in the original container with an attached photo!
Please bring only the amount of medication necessary for the week

<u>MEDICAL FORMS CHECKLIST FOR EACH CAMPER:</u>

□ Authorization for the Administration of Medication by School, Child Care, and Youth Camp Personnel (If over 18, not required)
□ Scouting America Annual Medical Form
□ Medical Addendum
□ Non-prescription medication must also be left at the Health Lodge. This is a state law.

Phone: 203.734.3329

https://www.housatonicscouting.org

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MEDICAL ADDENDUM SIGNATURE

(must be completed by parent / guardian for scouts under 18 years old)

Scout's Name: _____ Troop #: _____ Week(s): _____

This addendum to the annual scouting health and medical record is for Scouts under 18 years of age and is required to meet Connecticut Department of Health requirements.

I give my permission for the camp health officer/nurse to administer over the counter medications as directed by the camp position in the camp standing orders. the Housatonic council's policies on medications at Scout camp are written to comply with the national standards of the Boy Scouts of America and the state of Connecticut Health department.

If you do not wish to have any of the following over the counter medications administered, please cross out and initial.

Over-the-Counter Medications may include:

(Generics may be substituted)

- Tylenol by mouth, per weight / age dosing as needed every 4 to 6 hours
- Advil by mouth, per weight / age dosing as needed every 6 to 8 hours
- Bacitracin / Neosporin / Hydrogen Peroxide topically as needed
- Hydrocortisone Cream topically every 6 hours as needed
- Benadryl by mouth, per weight / age dosing as needed, per package directions
- Claritin by mouth, per package directions
- Sudafed by mouth, per package directions
- Zantac by mouth, per package directions
- Sunscreen topically, as needed
- Bug repellent topically, as needed every 2 to 4 hours
- Solarcaine / Aloe Vera topically as needed every 2 to 4 hours

Signature: _____ Date: _____

*****Reminder - Prescription medications must be in the original pharmacy container with label, this includes EPI-Pens. Please bring only amount needed for a camp. Failure to comply will result in the inability for the medications to be ministered at camp. Any medication not picked up within one week after scout leaves Camp will be destroyed.***

Phone: 203.734.3329

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Authorization for the Administration of Medication by School, Child Care, and Youth Camp Personnel

In Connecticut schools, licensed Child Day Care Centers and Group Day Care Homes, licensed Family Day Care Homes, and licensed Youth Camps administering medications to children shall comply with all requirements regarding the Administration of Medications described in the State Statutes and Regulations. Parents/guardians requesting medication administration to their child shall provide the program with appropriate written authorization(s) and the medication before any medications are administered. Medications must be in the original container and labeled with child's name, name of medication, directions for medication's administration, and date of the prescription.

Authorized Prescriber's Order (Physician, Dentist, Optometrist, Physician Assistant, Advanced Practice Registered Nurse or Podiatrist):

Name of Child/Student _____ Date of Birth____/____/____ Today's Date____/____/____

Address of Child/Student _____Town_____

Medication Name/Generic Name of Drug_____ Controlled Drug? ☐ YES ☐ NO

Condition for which drug is being administered: _____

Specific Instructions for Medication Administration _____

Dosage_____Method/Route_____

Time of Administration _____ If PRN, frequency_____

Medication shall be administered: Start Date: _____/_____/_____ End Date: _____/_____/_____

Relevant Side Effects of Medication _____ ☐ None Expected

Explain any allergies, reaction to/negative interaction with food or drugs_____

Plan of Management for Side Effects _____

Prescriber's Name/Title _____ Phone Number (_____) _____

Prescriber's Address _____ Town _____

Prescriber's Signature _____ Date ____/____/_____

School Nurse Signature (if applicable) _____

Parent/Guardian Authorization:

☐ I request that medication be administered to my child/student as described and directed above

☐ I hereby request that the above ordered medication be administered by school, child care and youth camp personnel and I give permission for the exchange of information between the prescriber and the school nurse, child care nurse or camp nurse necessary to ensure the safe administration of this medication. I understand that I must supply the school with no more than a three (3) month supply of medication (school only.)

☐ I have administered at least one dose of the medication to my child/student without adverse effects. (For child care only)

Parent/Guardian Signature_____ Relationship_____ Date ____/____/____

Parent /Guardian's Address _____Town_____State____

E-mail: _____ Cell Phone # (_____) _____-_____ Other Phone # (_____) _____-_____

SELF ADMINISTRATION AND /OR POSSESSION OF MEDICATION AUTHORIZATION/APPROVAL

Self-administration of medication may be authorized by the prescriber (when applicable) and school nurse (when applicable) and must be authorized by parent/guardian in accordance with board policy. In a school: 1. inhalers for asthma and cartridge injectors for life-threatening allergies require authorization by the prescriber and parent/guardian only; 2. students may possess, self-administer or possess and self-administer medications for medically-diagnosed life-threatening allergies; and 3. students who are six years of age or older may possess and self-apply an over-the-counter sunscreen product with only the parent/guardian written authorization.

1. Student to self-administer medication specified on this form: _____ YES _____NO
2. Student to possess medication specified on this form: _____ YES _____NO

Prescriber's Authorization and Signature: _____ Date:_____

Parent/Guardian Authorization and Signature: _____ Date: _____

School nurse (RN) Approval of self-administration (if applicable): _____ Date: _____

Printed Name of Individual Receiving Written Authorization and Medication _____

Title/Position/ _____ Date: _____

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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: _____

Prepared. For Life.®

680-001
2019 Printing

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: _____

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