Annual Health and Medical Record (ENG)

Section: 1 Get Ready! Be Prepared!

Lets Get Ready! Lets Get Prepared!

Things You Will Need to Complete Your Annual Health and Medical Record:

-Health History
-Insurance Information
(including a copy of both sides of your health insurance card to include with the mail-in portion (Part C) of the Annual Health and Medical Record)
-Immunization Records
-Allergy Information
-Medication Information

Once you have your information Prepared Lets Get Started!

If you require assistance, you may access the user manual at any time by clicking the help button in the Lower Right. If you require further assistance, please contact the BSA National Support Center at 972-580-2267.

You can Save your Progress Anytime and Continue your Application at a Later Date / Time.

Once you have submitted all of the required information online, you will be required to print Part C of the Annual Health and Medical Record and take it to your physician for completion. Once your physician has completed Part C of your Annual Health and Medical Record, make a copy for your records and mail the Part C along with a copy of both sides of your health insurance card to:

Boy Scouts of America
Event Registration
PO Box 152010
Irving, TX 75015
PERSONAL & CONFIDENTIAL

All completed Annual Health and Medical Record forms are due to the address above no later than April 15, 2013

If you are unable to use this online system to submit your medical information, you may download and use the printed form found at www.scouting.org/filestore/HealthSafety/pdf/part_c.pdf. This form should also be mailed to the address above.

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Section: 2 Part A - General Information

BSA Membership Id	124156852
First Name	Ariel
Last Name	Villarreal
Date of birth	1/23/1964
Gender	Male

Section: 3 Part A - Insurance Information

Health/accident insurance company (enter “none” if no insurance)	UMR
Policy No. (enter “none” if no insurance)	11838983

Section: 4 Part A - Emergency Contact Information

Name	Jill D Villarreal
Relationship	Wife
Address	17903 Bridle Way
City	Port Saint Lucie
State	FLORIDA
Zip / Postal Code	34987
Primary phone	9548500915
Alternate phone	7724894065
2nd Alternate phone	
Alternate contact name	Ariel Villarreal Jr
Alternate's phone	9548500219

Section: 5 Part A - Health History

Asthma	○ Yes ◉ No
Last Attack (MM/DD/YYYY)	

Explain

Diabetes	○ Yes ◉ No
Last HbA1c (Percentage)	

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Explain

Hypertension (high blood pressure) ○ Yes ◉ No

Explain

Heart disease/heart attack/chest pain/heart murmur ○ Yes ◉ No

Explain

Stroke/TIA ○ Yes ◉ No

Explain

Lung/respiratory disease ○ Yes ◉ No

Explain

Ear/sinus problems ○ Yes ◉ No

Explain

Muscular/skeletal condition ○ Yes ◉ No

Explain

Menstrual Problems? (Males answer N/A) N/A

Explain

Psychiatric/psychological and emotional difficulties ○ Yes ◉ No

Explain

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Behavioral/neurological disorders ○ Yes ◉ No

Explain

Bleeding disorders ○ Yes ◉ No

Explain

Fainting spells ○ Yes ◉ No

Explain

Thyroid disease ○ Yes ◉ No

Explain

Kidney disease ○ Yes ◉ No

Explain

Sickle cell disease ○ Yes ◉ No

Explain

Seizures ○ Yes ◉ No

Last seizure (MM/DD/YYYY) ☐☐ ☐☐ ☐☐☐☐

Explain

Sleep disorders (e.g., sleep apnea) ○ Yes ○ No

Use CPAP ○ Yes ◉ No

Explain

Abdominal/digestive problems ○ Yes ◉ No

Explain

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Surgery ○ Yes ◉ No

Last surgery (MM/DD/YYYY) ☐☐ ☐☐ ☐☐☐☐

Explain

Serious injury ○ Yes ◉ No

Explain

Excessive fatigue or shortness of breath with exercise ○ Yes ◉ No

Explain

Other (select “no” if none) ○ Yes ◉ No

Explain

Section: 6 Part A - Allergy or Adverse Reaction Information

Medication ◉ Yes ○ No

If Yes, please list medication and describe reaction
Penicillin

Food, plants, or insect bites ○ Yes ◉ No

If Yes, please list and describe reaction

Section: 7 Part A - Immunization Information

Tetanus : Have you been Immunized? ◉ Yes ○ No

Tetanus : Date of Last Immunization (Must be more recent than July 25th, 2003)

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	☐☐ ☐☐ ☐☐☐☐
Tetanus : Have had the Disease?	○ Yes ◉ No
Tetanus : Date of Disease (MM/DD/YYYY)	9/1/2007
Pertussis : Have you been Immunized?	○ Yes ◉ No
Pertussis : Date of Last Immunization? (MM/DD/YYYY)	☐☐ ☐☐ ☐☐☐☐
Pertussis : Have had the Disease?	○ Yes ◉ No
Pertussis : Date of Disease? (MM/DD/YYYY)	☐☐ ☐☐ ☐☐☐☐
Diphtheria : Have you been Immunized?	○ Yes ◉ No
Diphtheria : Date of Last Immunization? (MM/DD/YYYY)	☐☐ ☐☐ ☐☐☐☐
Diphtheria : Have had the Disease?	○ Yes ◉ No
Diphtheria : Date of Disease? (MM/DD/YYYY)	☐☐ ☐☐ ☐☐☐☐
Measles : Have you been Immunized?	◉ Yes ○ No
Measles : Date of Last Immunization? (MM/DD/YYYY)	10/1/2004
Measles : Have had the Disease?	○ Yes ◉ No
Measles : Date of Disease? (MM/DD/YYYY)	☐☐ ☐☐ ☐☐☐☐
Mumps : Have you been Immunized?	◉ Yes ○ No
Mumps : Date of Last Immunization? (MM/DD/YYYY)	10/1/2004
Mumps : Have had the Disease?	◉ Yes ○ No
Mumps : Date of Disease? (MM/DD/YYYY)	☐☐ ☐☐ ☐☐☐☐
Rubella : Have you been Immunized?	◉ Yes ○ No
Rubella : Date of Last Immunization? (MM/DD/YYYY)	10/1/2004
Rubella : Have had the Disease?	○ Yes ◉ No
Rubella : Date of Disease? (MM/DD/YYYY)	☐☐ ☐☐ ☐☐☐☐
Polio : Have you been Immunized?	◉ Yes ○ No
Polio : Date of Last Immunization? (MM/DD/YYYY)	6/1/2002
Polio : Have had the Disease?	○ Yes ◉ No
Polio : Date of Disease? (MM/DD/YYYY)	☐☐ ☐☐ ☐☐☐☐
Chicken Pox : Have you been Immunized?	○ Yes ○ No
Chicken Pox : Date of Last Immunization? (MM/DD/YYYY)	☐☐ ☐☐ ☐☐☐☐
Chicken Pox : Have had the Disease?	◉ Yes ○ No
Chicken Pox : Date of Disease? (MM/DD/YYYY)	☐☐ ☐☐ ☐☐☐☐
Hepatitis A : Have you been Immunized? (MM/DD/YYYY)	◉ Yes ○ No

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Hepatitis A : Date of Last Immunization? (MM/DD/YYYY)	6/1/2002
Hepatitis A : Have had the Disease?	○ Yes ◉ No
Hepatitis A : Date of Disease? (MM/DD/YYYY)	
Hepatitis B : Have you been Immunized?	◉ Yes ○ No
Hepatitis B : Date of Last Immunization? (MM/DD/YYYY)	12/1/1998
Hepatitis B : Have had the Disease?	○ Yes ◉ No
Hepatitis B : Date of Disease? (MM/DD/YYYY)	
Meningitis : Have you been Immunized?	○ Yes ◉ No
Meningitis : Date of Last Immunization? (MM/DD/YYYY)	
Meningitis : Have had the Disease?	○ Yes ○ No
Meningitis : Date of Disease? (MM/DD/YYYY)	
Influenza : Have you been Immunized?	○ Yes ◉ No
Influenza : Date of Last Immunization? (MM/DD/YYYY)	
Influenza : Have had the Disease?	○ Yes ○ No
Influenza : Date of Disease? (MM/DD/YYYY)	
Other (e.g., shingles, pneumonia, etc.) : Have you been Immunized?	○ Yes ◉ No

If Yes, list immunization(s) and Date of Immunization:

Other (e.g., shingles, pneumonia, etc.) : Have had the Disease?	○ Yes ◉ No

If Yes, list Disease(s) and Date of Infection:

Exemption to immunizations claimed (form required).	○ Yes ○ No

Section: 8 Part A - Medication Information

Medications - Are you Currently Using Any Medications	No medications
Additional medications (sheet attached)	○ Yes ○ No
Medication	
Strength	
Frequency	

Reason for medication

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Medication

Strength

Frequency

Reason for medication

Medication

Strength

Frequency

Reason for medication

Medication

Strength

Frequency

Reason for medication

Medication

Strength

Frequency

Reason for medication

Medication

Strength

Frequency

Reason for medication

Medication

Strength

Frequency

Reason for medication

Youth only: Administration of the above medications is approved by parent/guardian (Adults - answer N/A)

Administration of the above medications is approved by healthcare provider

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.

Section: 9 Part B - Informed Consent and Release Agreement

INFORMED CONSENT AND RELEASE AGREEMENT

I understand that participation in Scouting activities involves a certain degree of risk and can be physically, mentally, and emotionally demanding. I also understand that participation in these activities is entirely voluntary and requires participants to abide by applicable rules and standards of conduct.

In case of an emergency involving me or my child, I understand that every effort will be made to contact the individual listed as the emergency contact person. 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.

I have carefully considered the risk involved and give consent for myself and/or my child to participate in these activities. I approve the sharing of the information on this form with BSA volunteers and professionals who need to know of medical situations that might require special consideration for the safe conducting of Scouting activities.

I 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 claims or liability arising out of this participation.

With special considerations or restrictions ○ Yes ○ No

(special considerations or restrictions list)

Annual Health and Medical Record (ENG)

Section: 10 Part C - Page 1

TO THE EXAMINING HEALTH CARE PROVIDER
(Certified and licensed physicians [MD, DO], nurse practitioners, and physician assistants)
You are being asked to certify that this individual has no contraindication for participation in a Scouting experience as described in Part D. For individuals who will be attending a high-adventure program, either unit-based or at one of the national high-adventure bases, please refer to Part D for additional information.

PARA EL PROVEEDOR DE SERVICIOS DE SALUD QUE REALICE EL RECONOCIMIENTO (Médicos certificados y licenciados, enfermeras profesionales y asistentes médicos)
Se les está solicitando que certifiquen que este individuo no tiene contraindicación para participar en una experiencia Scouting tal como se describe en la Parte D. Para individuos que estarán participando en un programa de aventura extrema, ya sea en la unidad o en una de las bases nacionales de aventura extrema, por favor consulte la Parte D para información adicional.

Height (inches) Estatura (pulgadas) ☐☐.☐ Weight (pounds) Peso (libras) ☐☐☐.☐ Maximum weight for height Máximo peso para la estatura ☐☐☐ Meets height/weight limits Cumple con los límites de estatura/peso ◯ Yes/Sí ◯ No/No

Blood pressure Presión arterial ☐☐☐/☐☐☐ Pulse Pulso ☐☐☐ Percent body fat (optional) Porcentaje de grasa corporal (opcional) ☐☐☐.☐

If you exceed the maximum weight for height as explained on the next page and your planned high-adventure activity will take you more than 30 minutes away from an emergency vehicle/accessible roadway, you **will not** be allowed to participate. At the discretion of the medical advisers of the event and/or camp, participation of an individual exceeding the maximum weight for height may be allowed if the body fat percentage measured by the health care provider is determined to be 20 percent or less for a female or 15 percent or less for a male. (Philmont requires a hydrostatic weighing or DXA test to be used for this determination.) Please call the event leader and/or camp if you have any questions. Enforcing the height/weight guidelines is strongly encouraged for all other events.

Si usted excede el peso máximo para su estatura tal como se explica en la siguiente página y su actividad de aventura extrema planeada le llevará a más de 30 minutos de distancia de una vía con acceso para un vehículo de emergencia, usted **no podrá** participar. A juicio de los consejeros médicos del evento o campamento, la participación de un individuo que exceda el peso máximo para su estatura puede permitirse si el porcentaje de grasa corporal medida por el proveedor de servicios de salud determina que es 20 por ciento o menos para una mujer o 15 por ciento o menos para un hombre. (Philmont requiere que se use una prueba de peso hidrostático o de densitometría ósea para determinarlo). Por favor llame al líder del evento o del campamento si tiene preguntas. El cumplimiento de los lineamientos de estatura y peso se recomienda encarecidamente para todos los demás eventos.

Examiner: Please fill in the information.
Examinador: Favor de completar la información.

Please fill in the bubbles as indicated: Por favor rellene los círculos tal como se indica: Incorrect: Incorrecto ✓ ✗ ◒ Correct: Correcto ●

	Normal Normal	Abnormal Anormal	Explain Any Abnormalities Explique cualquier anomalía
Eyes Ojos	◯	◯	
Ears Oídos	◯	◯	
Nose Nariz	◯	◯	
Throat Garganta	◯	◯	
Lungs Pulmones	◯	◯	
Neurological Neurológico	◯	◯	
Heart Corazón	◯	◯	
Abdomen Abdomen	◯	◯	
Genitalia/hernia Genitales/hernia	◯	◯	
Skin Piel	◯	◯	
Emotional adjustment Ajuste emocional	◯	◯	

Range of Mobility Rango de movilidad	Normal Normal	Abnormal Anormal	Explain Any Abnormalities Explique cualquier anomalía
Knees (both) Rodillas (ambas)	◯	◯	
Ankles (both) Tobillos (ambos)	◯	◯	
Spine Espina	◯	◯	

Other Otro	Yes Sí	No No	Explain Explique
Personal or family history of heart disease Historial personal o familiar de enfermedad cardíaca	◯	◯	
Medical equipment (i.e., CPAP, oxygen) Equipo médico (por ejemplo, CPAP, oxígeno)	◯	◯	
Contacts Lentes de contacto	◯	◯	
Dentures Dentaduras	◯	◯	
Braces Tratamientos de ortodoncia	◯	◯	

Tuberculosis (TB) skin test (if required by your state for BSA camp staff): ◯ Negative/Negativo ◯ Positive/Positivo
Prueba de Tuberculosis (TB) (si lo requiere su estado para personal del campamento BSA)

Allergies/Alergias: ◯ No/No ◯ Yes/Sí (explain to what agent, type of reaction, treatment/explique a qué agente, tipo de reacción, tratamiento):

Medical restrictions to participate/Restricciones médicas para participar: ◯ No/No ◯ Yes/Sí (explain/explique):

0 00124 15685 2

DOB: 1/23/1964

Full Name: Ariel Villarreal

EXAMINER'S CERTIFICATION
CERTIFICACIÓN
DEL EXAMINADOR

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 above):

Certifico que he revisado el historial médico, examinado a esta persona y no encuentro contradicciones para su participación en una experiencia Scouting. Este participante (con las restricciones descritas anteriormente):

Please fill in the bubbles as indicated:
Por favor rellene los círculos tal como se indica:

Incorrect: ✓ ✗ ◒ Incorrecto — Correct: ● Correcto

True Cierto	False Falso	
○	○	**Meets height/weight requirements** Cumple con los requisitos de estatura/peso
○	○	**Does not have uncontrolled heart disease, asthma, or hypertension** No tiene cardiopatía, asma o hipertensión incontrolados
○	○	**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** No ha tenido una lesión ortopédica, problemas musculoesqueléticos o cirugía ortopédica en los últimos seis meses o posee una carta de autorización por parte de su cirujano ortopédico o médico
○	○	**Has no uncontrolled psychiatric disorders** No tiene trastornos psiquiátricos incontrolados
○	○	**Has had no seizures in the last year** No ha tenido convulsiones en el último año
○	○	**Does not have poorly controlled diabetes** No tiene diabetes mal controlada
○	○	**If less than 18 years of age and planning to scuba dive, does not have diabetes, asthma, or seizures** Si tiene menos de 18 años de edad y piensa realizar buceo, no tiene diabetes, asma o convulsiones
○	○	**I have reviewed Part D for high-adventure activities.** He revisado la Parte D para actividades de aventura extrema.

Provider printed name
Nombre del proveedor _____

Address
Domicilio _____

City, state, zip
Ciudad, estado, código postal _____

Office phone
Teléfono del consultorio _____

Date
Fecha _____

Examiner signature in the box below.
Firma del examinador en el recuadro de abajo.

Height (inches) Estatura (pulgadas)	Recommended Weight (lbs) Peso recomendado (libras)	Allowable Exception Excepción permitida	Maximum Acceptance Aceptación máxima
60	97-138	139-166	166
61	101-143	144-172	172
62	104-148	149-178	178
63	107-152	153-183	183
64	111-157	158-189	189
65	114-162	163-195	195
66	118-167	168-201	201
67	121-172	173-207	207
68	125-178	179-214	214
69	129-185	186-220	220
70	132-188	189-226	226
71	136-194	195-233	233
72	140-199	200-239	239
73	144-205	206-246	246
74	148-210	211-252	252
75	152-216	217-260	260
76	156-222	223-267	267
77	160-228	229-274	274
78	164-234	235-281	281
79 & over	170-240	241-295	295

This table is based on the revised Dietary Guidelines for Americans from the U.S. Dept. of Agriculture and the Dept. of Health & Human Services.

Esta tabla está basada en los Lineamientos dietéticos para estadounidenses del Departamento de Agricultura de los EE.UU. y del Departamento de Salud y Servicios Humanos.

DO NOT WRITE IN THIS BOX
NO ESCRIBA EN ESTE RECUADRO

REVIEW FOR CAMP OR SPECIAL ACTIVITY/REVISIÓN PARA CAMPAMENTO O ACTIVIDAD ESPECIAL

Reviewed by
Revisado por _____

Date
Fecha _____

Further approval required ○ Yes Sí ○ No No
Se requiere aprobación adicional

Reason
Razón _____

Approved by
Aprobado por _____

Date
Fecha _____