a sample form to explain the AHR

Annual Health and Medical Record

Information and FAQs

Personal Health and the Annual Health and Medical Record

Find the current Annual Health and Medical Record by using this QR code or by visiting http://www.scouting.org/HealthandSafety/ahmr.aspx.

The Scouting adventure, camping trips, high-adventure excursions, and having fun are important to everyone in Scouting—and so are your safety and well-being. Completing the Annual Health and Medical Record is the first step in making sure you have a great Scouting experience. **So what do you need?**

All Scouting Events. All participants in all Scouting activities complete Part A and Part B. Give the completed forms to your unit leader. This applies to all activities, day camps, local tours, and weekend camping trips less than 72 hours. Update at least annually.

Part A is an informed consent, release agreement, and authorization that needs to be signed by every participant (or a parent and/or legal guardian for all youth under 18).

Part B is general information and a health history.

Going to Camp? A pre-participation physical is needed for resident, tour, or trek camps or for a Scouting event of more than 72 hours, such as Wood Badge and NYLT. The exam needs to be completed by a certified and licensed physician (MD, DO), nurse practitioner, or physician assistant. If your camp has provided you with any supplemental risk information, or if your plans include attending one of the four national high-adventure bases, share the venue's risk advisory with your medical provider when you are having your physical exam.

Part C is your pre-participation physical certification.

Planning a High-Adventure Trip? Each of the four national high-adventure bases has provided a supplemental risk advisory that explains in greater detail some of the risks inherent in that program. All high-adventure participants **must** read and share this information with their medical providers during their pre-participation physicals. Additional information regarding high-adventure activities may be obtained directly from the venue or your local council.

Prescription Medication. Taking prescription medication is the responsibility of the individual taking the medication and/or that individual's parent or guardian. A leader, after obtaining all the necessary information, can agree to accept the responsibility of making sure a youth takes the necessary medication at the appropriate time, but the BSA does not mandate or necessarily encourage the leader to do so. Standards and policies regarding administration of medication may be in place at BSA camps. If state laws are more limiting than camp policies, they must be followed. The AHMR also allows for a parent or guardian to authorize the administration of nonprescription medication to a youth by a camp health officer or unit leader, including any noted exceptions.

Risk Factors. Scouting activities can be physically and mentally demanding. Listed below are some of the risk factors that have been known to become issues during outdoor adventures.

- Exessive body weight (obesity)
- Cardiac or cardiovascular disease
- Hypertension (high blood pressure)
- Diabetes mellitus
- Seizures
- Asthma
- Sleep apnea
- Allergies or anaphylaxsis
- Musculoskeletal injuries
- Psychological and emotional difficulties

More in-depth information about risk factors can be found by using this QR code or by visiting http://www.scouting.org/HealthandSafety/risk_factors.aspx

Questions?

Q. Why does the BSA require all participants to have an Annual Health and Medical Record?

A. The AHMR serves many purposes. Completing a health history promotes health awareness, collects necessary data, and provides medical professionals critical information needed to treat a patient in the event of an illness or injury. It also provides emergency contact information.

Poor health and/or lack of awareness of risk factors have led to disabling injuries, illnesses, and even fatalities. Because we care about our participants' health and safety, the Boy Scouts of America has produced and required the use of standardized health and medical information since at least the 1930s.

The medical record is used to prepare for high-adventure activities and increased physical activity. In some cases, it is used to review participants' readiness for gatherings like the national Scout jamboree and other specialized activities.

Because many states regulate the camping industry, this Annual Health and Medical Record also serves as a tool that enables councils to operate day and resident camps and adhere to state and BSA requirements. The Boy Scouts of America Annual Health and Medical Record provides a standardized mechanism that can be used by members in all 50 states.

For answers to more questions, use this QR code or visit the FAQ page at www.scouting.org/HealthandSafety/Resources/MedicalFormFAQs.aspx.

Download a free QR reader for your smartphone at scan.mobi.

Part A: Informed Consent, Release Agreement, and Authorization

A

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

B

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
☐	☐	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 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)
☐	☐	☐	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:

Write in the date
Photocopy not necessary

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 B: General Information/Health History

B

Full name: _____

DOB: _____

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

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☐ No☐**
☐	☐	List all surgeries and hospitalizations	**Last surgery date:**
☐	☐	List any other medical conditions not covered above	

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: _____

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

1 ☐ **Boy Scouts of America**
Annual Health and Medical Record

An Introduction by
Veronica Brozowski RN
Camp Constantin

2 ☐ **Why have it?**

The AHMR is a standardized record of a participant's health, medical status, and emergency contact information that can be used by a medical provider in case of illness or injury at *any* BSA function in *any* of the 50 states.

Being standardized, anyone coming in to a situation needing medical/health treatment already knows where to find crucial information.

3 ☐ **Where does someone get the form?**

At the website
http://www.scouting.org/healthandsafety/ahmr.aspx

Please use only this website to download the form.

4 ☐ **What is done with the AHMR?**

The paper forms are collected by the unit leaders and maintained in a safe and discreet manner for the duration of the event or activity only.

AHMR forms are not to be digitized, scanned, sent by email, or stored online by unit leaders. The electronic version of the AHMR is to be saved by the individual Scouts, not by the council, district, or unit.

The paper forms are best stored in a binder which is kept secure with disclosure of the contents made on a need-to-know basis only, and the forms returned to the Scout at the end of the camping session.

5 ☐ **Who needs the form?**

Anyone participating in any Scouting activity must have at least part of the AHMR completed.

Part A and Part B (three pages) must be completed for every youth, staff, parent, guardian, sibling and unit leader participating.
Part C is the Pre-Participation Physical, performed by a medical professional, annually.
Part C is required for participation in events over 72 hours long. Completion of Part C is *encouraged for all participants*, regardless of length of time participating.

6 ☐ **How often does this have to happen?**

Annually

The AHMR is valid for one year to the end of the month from the date it is signed by a medical professional.

An AHMR signed June 1, 2016 is valid until the 30th of June 2017; on July 1 2017, a new AHMR is required.

7 ☐ **Part A**

8 ☐ **Part A: informed Consent, Release Agreement, and Authorization**

Name
Date of Birth
List of Limitations or No limitations note the little box!
Participant's Signature
Parent/Guardian Signature for youth under age 18
Adults authorized to take youth to and from events: (2) names and phone numbers
Adults NOT authorized to take youth to and from events: names and phone numbers

9 ☐ **Part B side 1**

10 ☐ **Part B side 1**
General Information/Health History

Completed by the parent/guardian
Name, DOB, Age, Gender, Height, Weight
Address, Home phone number
Unit Leader with mobile phone number
Council Name and Troop number
Health Insurance Company, Policy Number, Photocopy of Insurance Card (both sides)

11 ☐ **Part B side 1 continued**

Emergency Contact names and phone numbers: primary and alternate

Health History
Yes or no: Do you currently have or have you ever had...
Diabetes
History of Heart disease
Asthma
Psychological or emotional difficulties

And so forth...

12 ☐ **Part B side 2**

13 ☐ **Part B side 2**

General Information/Health History

Name

DOB

Allergies/Medications

y/n Medications_____ y/n Plants_____

y/n Food _____ y/n Insect bites_____

14 ☐ **Part B side 2 continued**

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

__ Check here is no medications are routinely used

__ If additional space is needed, please indicate on a separate piece of paper

Medication Dose Frequency Reason

_____ ___ _____ _____

y/n Non-prescription medications is authorized with these exceptions

_____

15 ☐ **Part B side 2 continued**

Bring all medications in sufficient quantities

Make sure they are not expired

Include inhalers and Epi-Pens

You should not stop taking any maintenance medications unless instructed to do so by your doctor

Immunization

y/n immunized had the disease immunization date(s)

Tetanus, Pertussis, Diphtheria, MMR, etc.

Date the Tetanus shot received is required to participate in camp

Please List Any Additional Information about your medical history

16 ☐ **Part C**

17 ☐ **Part C Pre-Participation Physical**

This part must be signed by a licensed/certified physician (MD DO), nurse practitioner, or physician's assistant before you leave his/her office.

It must be dated within one year (to the end of the month) of the event.

It must include a legible name, address and phone number for the examiner.

18 ☐ **Part C continued**

Medical Restrictions to participate; explain.

- y/n Allergies/Reactions Explain_____

- Height____ Weight_____ Blood Pressure____ Pulse_____
- _____Normal Abnormal Explain Abnormalities
- Eyes, ears, lungs, etc.

Height/Weight Restrictions explained

Maximum weight for height chart

-

19 ☐ **Part C concluded**

Examiner's Certification

True/False Explain

- Meets height/weight requirements
- Does not have uncontrolled heart disease...
- Has not had an orthopedic injury....
- Has no uncontrolled psychiatric disorders...

Signature, Printed Name, Date, Address, Office phone are required

-