BSA CLASS 1 PERSONAL HEALTH AND MEDICAL HISTORY

(Annually by all participants)
To be filled out by parent, guardian, or adult participant. Please print in blue ink.
A Class 1 record is required annually for all participants. Includes any event that does *not exceed seventy-two consecutive hours*, where the level of activity is similar to that normally expended at home or at school, and where medical care is readily available. Examples: day camp, day hike, swimming party, or an overnight camp. Medical information required is *a current health history signed by parents or guardian*. This form is filled out by participants and kept on file for easy reference.

IDENTIFICATION

Name _____ Date of birth _____ Age ____ Sex ____

Name of parent or guardian _____ Telephone _____

Home address _____ City _____ State _____ Zip_____

Business address _____ City _____ State _____ Zip _____

If person above is not available in the event of an emergency, notify

Name _____ Relationship _____ Telephone _____

Name _____ Relationship _____ Telephone _____

Name of personal physician _____ Telephone _____

Health/accident insurance carrier _____ Policy/patient No_____

Check items that apply, past or present, to your health history. Explain any "Yes" answers.

ALLERGIES: Food, medicines, insects, plants: Yes ( ) No ( ) Explain: _____

GENERAL INFORMATION:	Yes	No		Yes	No		Yes	No
Asthma	( )	( )	Diabetes	( )	( )	High blood pressure	( )	( )
Cancer/leukemia	( )	( )	Heart trouble	( )	( )	Kidney disease	( )	( )
Convulsions/seizures	( )	( )	Hemophilia	( )	( )		( )	( )

Explain: _____

List any medications to be taken at camp:
_____

List any physical or behavioral conditions that may affect or limit full participation in swimming, backpacking, hiking long distances, or playing strenuous physical games:
_____
_____

List equipment needed such as wheelchair, contacts, etc.: _____

Date _____ Signature of parent/guardian or adult_____

In case of Emergency, I understand every effort will be made to contact me (if an adult, my spouse or next of kin). In the event I cannot be reached, I hereby give my permission to the physician selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child (or for me, if an adult).

Some hospitals require that the parent/guardian signature be notarized. Check with your BSA local council.
BSA form 34414 modified.

PARENTAL INFORMED CONSENT AND
RELEASE/INDEMNITY/HOLD-HARMLESS AGREEMENT

I understand participation in **COPE** offered through the **Narragansett** Council, BSA, on _____ involves a certain degree of risk that could result in injury or death. In consideration of the benefits to be derived and after carefully considering the risk involved, and in view of the fact that the Boy Scouts of America is an organization in which membership is voluntary, and having full confidence that precautions will be taken to ensure the safety and well-being of my (son/daughter), I have given _____(son/daughter) my consent to participate in **COPE,** and:

RELEASE AND INDEMNIFICATION

I hereby release and waive any and all claims that I may have against Boy Scouts of America **Narragansett** Council, BSA and their employees, agents, representatives, or volunteers arising from my child's participation in **COPE**. I AGREE TO FULLY INDEMNIFY AND HOLD HARMLESS BOY SCOUTS OF AMERICA **Narragansett** COUNCIL, BSA, AND THEIR EMPLOYEES, AGENTS, REPRESENTATIVES, AND VOLUNTEERS FROM ANY AND ALL CLAIMS ARISING FROM MY CHILD'S PARTICIPATION IN **COPE**. THIS INDEMNIFICATION EXPRESSLY INCLUDES ANY CLAIMS ARISING OUT OF THE BOY SCOUTS OF AMERICA **Narragansett** COUNCIL, BSA'S OWN NEGLIGENCE OR FAULT OR THAT OF THEIR EMPLOYEES, AGENTS, REPRESENTATIVES, OR VOLUNTEERS. I AGREE THAT THE INDEMNIFICATION INCLUDES THE AMOUNT OF THE CLAIMS, THE EXPENSES OF DEFENDING AGAINST THE CLAIMS, COURT COSTS, AND ATTORNEYS' FEES.

In case of emergency, I understand that every effort will be made to contact me. In the event I cannot be reached, I hereby give my permission to the physician selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child.

This form must have both parent/guardian signatures.

_____	_____
Signature	Signature
_____	_____
Telephone Number	Telephone Number
_____	_____
Date	Date