

UPDATED CAMP INFORMATION

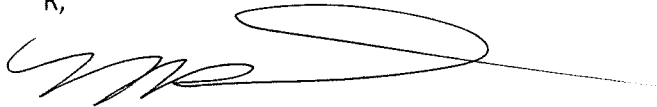
Parents,

There are a couple of changes that have been sent from camp. Please look at the attached.

1. There is an attachment after the physical form that needs to be filled out and signed with your physical by the doctor. This is authorization to give over the counter medicine if needed.
2. Merit badges – They have added a 5th period and spread things out so please review this and remember my goal is to have these by Wednesday 2 May so I can start working them to position the troop to getting the badges we want. Deadline is the 2nd of May for these.
3. As a reminder I need ALL physicals by 13 June. Please do not wait until the last minute on these as I have to get them sent forward to the camp.

Any questions please let me know.

R,

A handwritten signature in black ink, consisting of a series of loops and a long horizontal stroke extending to the right.

Mr. A

Part A: Informed Consent, Release Agreement, and Authorization

Full name: _____
DOB: _____

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

Informed Consent, Release Agreement, and Authorization

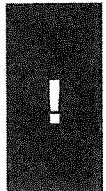
I understand that participation in Scouting activities involves the risk of personal injury, including death, due to the physical, mental, and emotional challenges in the activities offered. Information about those activities may be obtained from the venue, activity coordinators, or your local council. 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.

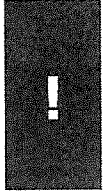
(If applicable) I have carefully considered the risk involved and hereby give my informed consent for my child to participate in all activities offered in the program. I further authorize the sharing of the information on this form with any BSA volunteers or professionals who need to know of medical 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: _____
Telephone: _____

ALL REGISTERED ADULT LEADERS

Name: _____
Telephone: _____

Adults NOT Authorized to Take Youth To and From Events:

Name: _____
Telephone: _____

Name: _____
Telephone: _____



Part B: General Information/Health History

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: NORM AUFLAND Mobile phone: 757 672 1162

Council Name/No.: TIDEWATER 596 Unit No.: 471

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
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	Last HbA1c percentage and date: _____
<input type="checkbox"/>	<input type="checkbox"/>	Hypertension (high blood pressure)	
<input type="checkbox"/>	<input type="checkbox"/>	Adult or congenital heart disease/heart attack/chest pain (angina)/heart murmur/coronary artery disease. Any heart surgery or procedure. Explain all "yes" answers.	
<input type="checkbox"/>	<input type="checkbox"/>	Family history of heart disease or any sudden heart-related death of a family member before age 50.	
<input type="checkbox"/>	<input type="checkbox"/>	Stroke/TIA	
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	Last attack date: _____
<input type="checkbox"/>	<input type="checkbox"/>	Lung/respiratory disease	
<input type="checkbox"/>	<input type="checkbox"/>	COPD	
<input type="checkbox"/>	<input type="checkbox"/>	Ear/eyes/nose/sinus problems	
<input type="checkbox"/>	<input type="checkbox"/>	Muscular/skeletal condition/muscle or bone issues	
<input type="checkbox"/>	<input type="checkbox"/>	Head injury/concussion	
<input type="checkbox"/>	<input type="checkbox"/>	Altitude sickness	
<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric/psychological or emotional difficulties	
<input type="checkbox"/>	<input type="checkbox"/>	Behavioral/neurological disorders	
<input type="checkbox"/>	<input type="checkbox"/>	Blood disorders/sickle cell disease	
<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells and dizziness	
<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	
<input type="checkbox"/>	<input type="checkbox"/>	Seizures	Last seizure date: _____
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal/stomach/digestive problems	
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	
<input type="checkbox"/>	<input type="checkbox"/>	Excessive fatigue	
<input type="checkbox"/>	<input type="checkbox"/>	Obstructive sleep apnea/sleep disorders	CPAP: Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	List all surgeries and hospitalizations	Last surgery date: _____
<input type="checkbox"/>	<input type="checkbox"/>	List any other medical conditions not covered above	

Part B: General Information/Health History

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	Yes	No	Allergies or Reactions	Explain
<input type="checkbox"/>	<input type="checkbox"/>	Medication		<input type="checkbox"/>	<input type="checkbox"/>	Plants	
<input type="checkbox"/>	<input type="checkbox"/>	Food		<input type="checkbox"/>	<input type="checkbox"/>	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 (Only required 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)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tetanus	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pertussis	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diphtheria	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Measles/mumps/rubella	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Polio	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Meningitis	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Influenza	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (i.e., Hib)	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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

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	<input type="checkbox"/>	<input type="checkbox"/>	

Yes	No	Allergies or Reactions	Explain	Yes	No	Allergies or Reactions	Explain
<input type="checkbox"/>	<input type="checkbox"/>	Medication		<input type="checkbox"/>	<input type="checkbox"/>	Plants	
<input type="checkbox"/>	<input type="checkbox"/>	Food		<input type="checkbox"/>	<input type="checkbox"/>	Insect bites/stings	

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

	Normal	Abnormal	Explain Abnormalities
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	
Ears/nose/throat	<input type="checkbox"/>	<input type="checkbox"/>	
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	
Heart	<input type="checkbox"/>	<input type="checkbox"/>	
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	
Genitalia/hernia	<input type="checkbox"/>	<input type="checkbox"/>	
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	

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
<input type="checkbox"/>	<input type="checkbox"/>	Meets height/weight requirements.
<input type="checkbox"/>	<input type="checkbox"/>	Does not have uncontrolled heart disease, asthma, or hypertension.
<input type="checkbox"/>	<input type="checkbox"/>	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.
<input type="checkbox"/>	<input type="checkbox"/>	Has no uncontrolled psychiatric disorders.
<input type="checkbox"/>	<input type="checkbox"/>	Has had no seizures in the last year.
<input type="checkbox"/>	<input type="checkbox"/>	Does not have poorly controlled diabetes.
<input type="checkbox"/>	<input type="checkbox"/>	If less than 18 years of age and planning to scuba dive, does not have diabetes, asthma, or seizures.
<input type="checkbox"/>	<input type="checkbox"/>	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



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**FIVE RIVERS COUNCIL
BOY SCOUTS OF AMERICA
Summer Camp Medication Permission Form**

Last Name: _____ First Name: _____ Unit: 471
 Address: _____ Unit Town: _____
 Phone: _____ DOB: _____ Weight: _____

Oral Agents	Dosage	Indication and Schedule	Camper Health Care Provider		Comments
			Approval	Initials	
Benadryl (Diphenhydramine)	<90# 25 mg => 90# 50 mg	Allergic Reaction/ Hay Fever every six hours as needed for 24 hours	Yes	No	
Imodium (loperamide)	Initial 4 tsp. repeat 2 tsp.	Diarrhea as needed for watery stool limit 8 tsp.	Yes	No	
Maalox	30 cc	Indigestion/ heartburn once	Yes	No	
Milk of Magnesia	30 cc	Constipation daily twice as needed	Yes	No	
Robitussin	Per label instructions	Colds every six hours as needed	Yes	No	
Tylenol (Acetaminophen)	15 mg/kg (below)	Fever, Headache, Pain Control, Toothache every 4 hours as needed	Yes	No	
Topical Agents	Dosage	Indication and Schedule	Camper Health Care Provider		Comments
Bacitracin	Per label instructions	Wound care twice daily and as needed	Yes	No	
Caladryl (Pramoxine)	Per label instructions	Insect Bites/ Poison Ivy twice daily and as needed	Yes	No	
Desenex Powder (Miconazole)	Per label instructions	Athletes Foot twice daily and as needed	Yes	No	
Lotrimin (clotrimazole)	Per label instructions	Jock Itch three times daily	Yes	No	

Tylenol Dosing				
Wt. (pounds)	50-75	75-95	95-150	>150
Dose	325 mg	500 mg	650 mg	1000 mg

Prescription or OTC medication	Dosage/ Route	Indication and Schedule	Camper Health Care Provider		Comments
			Self Administration	Initials	
			Yes	No	
			Yes	No	
			Yes	No	

Health Care Provider: _____ Phone: _____
 Address: _____ License: _____
 Health Care Provider signature: _____ Date: _____

I hereby give permission for my son/ daughter receive over the counter and prescription medications as indicated by my child's Health Care Provider and request self administration of prescription drugs. In addition, I give permission to carry and use sunscreen or insect repellent at camp and to use it throughout the day. If my child needs help re-applying sunscreen or insect repellent, I give permission for camp staff to provide my child with assistance if he/she requests it.

Signature of Parent or Guardian: _____ Date: _____

2018 Camp Gorton Merit Badge Schedule

Area	9:00 - 9:50	10:00 - 10:50	11:00 - 11:50	2:00 - 2:50	3:00 - 3:50
STEM	<i>Communications</i>	Chemistry	Moviemaking	Engineering	Moviemaking
	Chess	Theater		Aviation	Photography
	Electronics	Robotics	<i>Communications</i> OPEN PROGRAM	Geocaching	Robotics Music
FYRE	First Year Resident Experience				
Handicraft	Home Repairs	Space Exploration	Leatherworking	Space Exploration	Model Design & Building
	Wood Carving	Metalwork	Model Design & Building	Wood Carving	Woodwork
	Inventing	Game Design	OPEN PROGRAM	Leatherwork	Art
Nature	Bird Study	<i>Environmental Science</i>		Nature	Nature
	Archaeology	Fish and Wildlife Management	Astronomy	Reptile and Amphibian Studies	Insect Study
	Fly Fishing	Fly Fishing	Fishing	Fishing	Fishing
	Soil and Water Conservation	Geology	OPEN PROGRAM		
Scoutercraft	<i>Emergency Prep</i>	<i>Cooking</i>		<i>Emergency Prep</i>	Pioneering
	Fire Safety	Wilderness Survival		Safety	Orienteering
	<i>First Aid</i>	<i>Camping</i>	<i>First Aid</i>	Fire Safety	Wilderness Survival
	<i>Camping</i>		OPEN PROGRAM	Search and Rescue	<i>Camping</i>
Shooting Sports	Rifle - Over 12	Rifle - Over 12	Rifle - Over 12	Shotgun - Over 12	Shotgun - Over 12
		Archery	Archery	Archery	Archery
Waterfront	Rowing	Canoeing		<i>Swimming</i>	<i>Swimming</i>
	BSA Paddleboard	BSA Paddleboard	BSA Paddleboard	Instructional Swim	Instructional Swim
	Motorboating	Motorboating	Motorboating	Small Boat Sailing	
	Water Sports	Water Sports	<i>Swimming</i>	<i>Lifesaving</i>	
	Kayaking	Kayaking	Kayaking		

Skills and Advancement

Subject to Change

Eagle Required

MERIT BADGE SELECTION FORM

PERIOD	FIRST CHOICE	SECOND CHOICE
9-10		
10-11		
11-12		
2-3		
3-4		

Please review the requirements page on the badges because some require prior work before camp and some have age requirements. I will be happy to sit down with scouts and parents to determine what badges are the best for the scouts.

SCOUTS NAME: _____

PATROL: _____

DUE NO LATER THAN 2 May 2018 TO MR. AURLAND