Camper ID ________

THE NINTH INTERNATIONAL JAMBOREE OF VIETNAMESE SCOUTING
TRẠI HỌP BẠN HƯỚNG ĐẠO VIỆT NAM THẲNG TIẾN IX 2009
July 10 - 16, 2009 - San Lorenzo Park, King City, California, USA

HEALTH AND MEDICAL RECORD

PART A - GENERAL INFORMATION

Name: ____________________ Date of birth ________ Age _______ Male ☐ Female ☐
Address ____________________ Grade completed *(youth only)* _____
City: ____________ State __________ Zip____________ Phone No. ____________
Unit Leader ____________ Council name ____________ Unit No. ___________
Religious preference ____________
Health/accident insurance company ____________ Policy No. ____________
In case of emergency, notify:
Name ____________________ Relationship ____________
Address ____________________
Home phone ____________ Business phone ____________ Cell phone ____________
Alternate contact ____________ Alternate's phone ____________

MEDICAL HISTORY
Are you now, or have you ever been treated for any of the following

Yes	No	Condition	Explain
		Asthma	
		Diabetes	
		Hypertension (high blood pressure)	
		Heart disease (i.e., CHF, CAD, MI)	
		Stroke/TIA	
		COPD	
		Ear/sinus problems	
		Muscular/skeletal condition	
		Menstrual problems (women only)	
		Psychiatric/psychological and emotional difficulties	
		Learning disorders (i.e., ADHD, ADD)	
		Bleeding disorders	
		Fainting spells	
		Thyroid disease	
		Kidney disease	
		Sickle cell disease	
		Seizures	
		Sleep disorders (i.e., sleep apnea)	
		GI problems (i.e., abdominal, digestive)	
		Surgery	
		Serious injury	
		Other	

Allergies or Reaction to:
Medication ____________
Food, Plants, or Insect Bites ____________
____

Immunizations:
The following are recommended by the BSA. Tetanus immunization must have been received within the last 10 years. If had disease, put "D" and the year. If immunized, check the box and enter the year received.

Yes	No	Date
☐	☐	Tetanus ________
☐	☐	Pertussis ________
☐	☐	Diptheria ________
☐	☐	Measles ________
☐	☐	Mumps ________
☐	☐	Rubella ________
☐	☐	Polio ________
☐	☐	Chicken pox ________
☐	☐	Hepatitis A ________
☐	☐	Hepatitis B ________
☐	☐	Influenza ________

☐ Exemption to immunizations claimed.
(For more information about immunizations, as well as the immunization exemption form, see Scouting Safely on Scouting.org.)

MEDICATIONS
List all medications currently used. (If additional space is needed, please photocopy this part of the health form.) Inhalers and EpiPen information must be included, even if they are for occasional or emergency use only.

Medication ________ Strength ________ Frequency ________ Reason for medication ________ Approximate date started ________ Temporary ☐ Permanent ☐	Medication ________ Strength ________ Frequency ________ Reason for medication ________ Approximate date started ________ Temporary ☐ Permanent ☐	Medication ________ Strength ________ Frequency ________ Reason for medication ________ Approximate date started ________ Temporary ☐ Permanent ☐
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NOTE: Be sure to bring medications in the appropriate containers, and make sure that they are NOT expired, including inhalers and EpiPens. You SHOULD NOT STOP taking any maintenance medication.

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PART 2 - PHYSICAL EXAMINATION

Certified and licensed health-care providers perform this exam include physicians (MD, DO)

Height __________ Weight ___________ Meets height/weight limits Yes ☐ No ☐ Blood pressure _____________ Pulse_____________

	Normal	Abnormal	Explain Any Abnormalities	Range of Mobility	Normal	Abnormal	Explain Any Abnormalities
Eyes				Knees (both)			
Ears				Ankles (both)			
Nose				Spine			
Throat							
Lungs				**Other**	**Yes**	**No**	
Heart				Contacts			
Abdomen				Dentures			
Genitalia				Braces			
Skin				Inguinal hernia			**Explain**
Emotional adjustment				Medical equipment (i.e., CPAP, oxygen)			

Allergies (to what agent, type of reaction, treatment):

____

I certify that I have, today, reviewed the health history, examined this person, and approve this individual for participation in:

☐ Hiking and camping
☐ Sports
☐ Competitive activities
☐ Horseback riding
☐ Backpacking
☐ Scuba diving
☐ Swimming/water activities
☐ Mountain biking
☐ Climbing/rappelling
☐ Challenge ("ropes") course
☐ Wilderness/backcountry treks
☐ Cold weather activity (<10 F)

Specify restrictions (if none, so state)

____

To Health Care Provider: Restricted approval includes:

- ► Uncontrolled heart disease, asthma, or hypertension.
- ► Uncontrolled psychiatric disorders.
- ► Poorly controlled diabetes.
- ► Orthopedic injuries not cleared by a physician.
- ► Newly diagnosed seizure events (within 6 months).
- ► For scuba, use of medications to control diabetes, asthma, or seizures

Provider printed name ______________________________
Signature ______________________________
Address ______________________________
City, state, zip ______________________________
Office phone ______________________________
Date ______________________________

PART 3 - Consent and Hold Harmless/Release Agreement

I understand that participation in Scouting activities involves a certain degree of risk. I have carefully considered the risk involved and have given consent for myself or my child to participate in these activities. I understand that participation in these activities is entirely voluntary and requires participants to abide by applicable rules and standards of conduct. I release the Boy Scouts of America, Girl Scout of the USA, 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.

I approve the sharing of the information on this form with BSA / GSUSA volunteers and professionals who need to know of medical situations that might require special consideration for the safe conducting of Scouting activities.

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 to the adult in charge 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.

☐ Without restrictions. ☐ With special considerations or restrictions (list)

____

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.

Participant's name ______________________________

Participant's signature ______________________________

Parent/guardian's signature ______________________________
(If under the age of 18)

Date ______________________________

THẮNG TIẾN IX
July 10 -16 2009
KING CITY - CA - U.S.A