



Adventure › Character › Leadership

An additional medical form is **required** for Trail Life USA activities or events that exceed 72 hours in duration or include high altitude or high-exertion activities. That High Adventure Medical form requires the examination by and the signature of a doctor or health care professional.

## YOUTH Weekend Health and Medical Record

Participant's Name \_\_\_\_\_ Date of birth \_\_\_\_\_ Age \_\_\_\_\_  
(MM/DD/YYYY)

Address \_\_\_\_\_ Grade completed \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone # \_\_\_\_\_

Troop Leader \_\_\_\_\_ Troop# \_\_\_\_\_

### Emergency Contacts:

Mother's Name \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Father's Name \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

### Other emergency contact if parents cannot be reached:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

### Health/accident insurance information:

- Member does not have health care coverage at this time (Please skip to next section – Physician Information)  
 Member has health care coverage as listed below

Health/accident insurance company # 1 \_\_\_\_\_ Policy # \_\_\_\_\_

Policy Holder \_\_\_\_\_ Group # \_\_\_\_\_ Effective Date \_\_\_\_\_

Health/accident insurance company # 2 \_\_\_\_\_ Policy # \_\_\_\_\_

Policy Holder \_\_\_\_\_ Group # \_\_\_\_\_ Effective Date \_\_\_\_\_

ATTACH A PHOTOCOPY OF BOTH SIDES OF INSURANCE CARD.

### Physician Information:

Primary Care Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Physician's address \_\_\_\_\_

Dentist's name \_\_\_\_\_ Phone # \_\_\_\_\_

Preferred Hospital \_\_\_\_\_

<b>ALLERGIES</b>	Please list all known allergies including those to any medications, food and environment. If none are known, please write "none known". Attach additional page to this form if needed.
Allergy to:	Normal reaction and management of the reaction:

<b>HEALTH HISTORY</b>		Do you currently have, or have you ever been treated for any of the following?		
Yes	No	Condition		Explain
		Asthma	Last attack: (MM/YY)	
		Diabetes	Last HbA1c: (Percentage)	
		Hypertension (high blood pressure)		
		Heart disease/heart attack/chest pain/heart murmur		
		Stroke/TIA		
		Lung/respiratory disease		
		Ear/sinus problems		
		Muscular/skeletal condition		
		Psychiatric/psychological and emotional difficulties		
		Behavioral/neurological disorders		
		Bleeding disorders		
		Fainting spells		
		Thyroid disease		
		Kidney disease		
		Sickle cell disease		

		Seizures	Last seizure: (MM/YY)		
		Sleep disorders (e.g., sleep walking, sleep apnea)	Use CPAP?		
		Abdominal/digestive problems			
		Surgery	Last surgery: (MM/YY)		
		Serious injury			
		Excessive fatigue or shortness of breath with exercise			
		Other			

IMMUNIZATIONS		The following immunizations are recommended. For each item, indicate if you have been immunized, the date of the immunization (MM/YY), if you have had the disease, and the date (MM/YY).				
Yes	No	Immunization	Date of Immunization	Please indicate if you have had the disease		Date of Disease
			(MM/YY)	Yes	No	(MM/YY)
		Tetanus				
		Pertussis				
		Diphtheria				
		Measles				
		Mumps				
		Rubella				
		Polio				
		Chicken Pox				
		Hepatitis A				
		Hepatitis B				
		Meningitis				
		Influenza				
		Other (i.e., Hib)				

Full Name: \_\_\_\_\_

Emergency Contact #: \_\_\_\_\_

<b>MEDICATIONS</b>		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. If none, please write "None" below.		
Medication	Strength	Frequency	Approximate Date Started	Reason

Administration of the above medications and such over-the-counter medications as may be deemed necessary for the health and safety of Participant is approved by (if required by your state):

\_\_\_\_\_ and/or \_\_\_\_\_  
 Parent/guardian signature MD/DO, NP, or PA signature (where required by state law for the dispensation of medications by a non-parent)

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.

No Trail Life youth member is allowed to self-medicate while participating in a Trail Life event. The only exceptions include emergency use medications such as by an inhaler, insulin syringe, or epi-pen, provided that the Trailman understands its proper use. Parents must indicate in writing that the youth is in possession of such medication and possesses the knowledge and ability to administer it to himself.

I do hereby attest that the youth participant is able to self-administer the above listed emergency use medications in case of emergency if no approved adult leader is present to administer.

\_\_\_\_\_ Parent/guardian signature

**ADULTS AUTHORIZED TO TAKE YOUTH TO AND FROM EVENTS:**

You must designate at least one adult. Please include a telephone number.

1. Name \_\_\_\_\_ Telephone \_\_\_\_\_

2. Name \_\_\_\_\_ Telephone \_\_\_\_\_

3. Name \_\_\_\_\_ Telephone \_\_\_\_\_

**Adults NOT authorized to take youth to and from events:**

1. Name \_\_\_\_\_ Telephone \_\_\_\_\_

2. Name \_\_\_\_\_ Telephone \_\_\_\_\_

3. Name \_\_\_\_\_ Telephone \_\_\_\_\_

**Full Name:** \_\_\_\_\_

**Emergency Contact #:** \_\_\_\_\_

**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.**

I give permission for full participation in Trail Life USA activities, except where specifically limited in writing herein.

This Health and Medical Record is correct and complete, as far as I know. I hereby give permission for Trail Life USA leadership to administer prescribed and over the counter medications.

In case of emergency, I understand every effort will be made to contact me. In the event that I cannot be reached, I hereby give my permission to the licensed health-care provider selected by the Trail Life USA adult leader(s) to secure proper treatment, including related transportation, hospitalization, anesthesia, surgery, or injections of medication for my child, except as noted below. I agree to the release of records necessary for treatment.

Notes:

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Participant's signature

Date

Parent/guardian's signature  
(if participant is under age 18)

Date

Second parent/guardian  
signature  
(if required, for example, CA)

Date

**This Weekend Health and Medical Record is valid for 12 calendar months.**