Order of the Arrow Tahosa Lodge - Medical Form Packet

This packet contains all the current required forms, please **DO NOT** substitute any other forms. Please read the following information carefully. The health and safety of our Scouts and Adults is our top priority. Incomplete or inaccurate information may place Scout and Adult at risk in an emergency or delay appropriate treatment. Lodge does NOT need originals, submit CLEAR copies. We recommend you keep a complete medical form packet copy for yourself. All medical forms provided will remain on file for the current calendar year and not returned.

Part A- Consent and Release

___ Read / fill in bullet / list any restrictions
___ Parent and Scout signatures
___ Complete - Adult Authorized to transport youth. Someone **MUST BE LISTED** even if it is yourself
___ Complete - Adults **NOT** authorized to transport youth or mark N/A. (**Colorado Requirement**)

Part B- Medical History

__ Provide 2 emergency contacts with phone numbers that will be available when camping
***** Colorado requires one NON- PARENT emergency contact*****
__ Include a clear photocopy of **BOTH** sides of your health insurance card- See included form
__ Complete health history with explanations for "Yes" answers. Check **ALL 4** allergy boxes YES or NO
__ Check **NO MEDICATIONS** if appropriate. Physician signature is required even with no medications
__ Clearly list all medications with: Medication, Dose, Frequency and Reason- Medications need to be in original dispensed bottles for administration during camp
*****Please include Colorado Asthma Care Plan, Self Administration Medication Contract and Anaphylaxis Care Plan, if your Scout uses inhaler or Epi- Pen*****
__ Immunizations- check appropriate box, complete dates

Over the Counter medication permission form

__ Please mark "Yes" OR "No" for each medication listed and indicate any allergy information

Anaphylaxis, Asthma Care Plan- if applicable

__ Please fill out completely with physician signature, if applicable

Self Administration Medication Contract- if applicable

__ Fill out top portion with all information
__ Scout and Parent / Guardian to acknowledge and sign

Departure Day Screening Form

__ Fill out for each scout or adult attending.

Part A: Informed Consent, Release Agreement, and Authorization

A

Full name: _____

Date of birth: _____

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.

Every person who furnishes any BB device to any minor, without the express or implied permission of the parent or legal guardian of the minor, is guilty of a misdemeanor. (California Penal Code Section 19915[a]) My signature below on this form indicates my permission.

I give permission for my child to use a BB device. (Note: Not all events will include BB devices.)

☐ **Checking this box indicates you DO NOT want your child to use a BB device.**

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 Scout Ranch, Philmont Training Center, Northern Tier, 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)

Complete this section for youth participants only:

Adults Authorized to Take Youth to and From Events:

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

Name: _____ Name: _____

Phone: _____ Phone: _____

Adults NOT Authorized to Take Youth to and From Events:

Name: _____ Name: _____

Phone: _____ Phone: _____

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Part B1: General Information/Health History

B1

Full name: _____

Date of birth: _____

High-adventure base participants:

Expedition/crew No.: _____

or staff position: _____

Age: _____ Gender: _____ Height (inches): _____ Weight (lbs.): _____

Address: _____

City: _____ State: _____ ZIP code: _____ Phone: _____

Unit leader: _____ Unit leader's mobile #: _____

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:** **Insulin pump: Yes** ☐ **No** ☐
☐	☐	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/reactive airway disease	**Last attack date:**
☐	☐	Lung/respiratory disease	
☐	☐	COPD	
☐	☐	Ear/eyes/nose/sinus problems	
☐	☐	Muscular/skeletal condition/muscle or bone issues	
☐	☐	Head injury/concussion/TBI	
☐	☐	Altitude sickness	
☐	☐	Psychiatric/psychological or emotional difficulties	
☐	☐	Neurological/behavioral disorders	
☐	☐	Blood disorders/sickle cell disease	
☐	☐	Fainting spells and dizziness	
☐	☐	Kidney disease	
☐	☐	Seizures or epilepsy	**Last seizure date:**
☐	☐	Abdominal/stomach/digestive problems	
☐	☐	Thyroid disease	
☐	☐	Skin issues	
☐	☐	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 B2: General Information/Health History

B2

Full name: _____

Date of birth: _____

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

Allergies/Medications

DO YOU USE AN EPINEPHRINE AUTOINJECTOR? ☐ YES ☐ NO Exp. date (if yes) _____

DO YOU USE AN ASTHMA RESCUE INHALER? ☐ YES ☐ NO Exp. date (if yes) _____

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 list 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. 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:

_____

_____

_____

_____

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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Denver Area Council – Boy Scouts of America Tahosa Lodge – Order of the Arrow

Scout Name:_____ **Date of Birth:**_____

Allergic to:_____

Over-the Counter Medication Dispensation Permission Form

Purpose: The Medical Staff has limited supplies of the medications listed below, if you know your scout will possibly need one of these, please send it (preferably new) with them, in the original container and labeled with their name.

YOU ARE GIVING PERMISSION FOR THE FOLLOWING MEDICATIONS TO BE GIVEN IF INDICATED, IF NEEDED. MEDICATIONS WILL BE ADMINISTERED IN ACCORDANCE WITH THE DOSAGES ON THE OTC MEDICAL CONTAINER

YES	NO	**Medication**
O	O	Acetaminophen (Tylenol®)
O	O	Ibuprofen (Advil®/Motrin®)
O	O	Diphenhydramine (Benadryl®)
O	O	Loratadine (Claritin®)
O	O	Cetirizine HCL (Zyrtec®)
O	O	Cough Drops or Throat Lozenges
O	O	1% Hydrocortisone Cream
O	O	Antibiotic topical ointment (Bacitracin®)
O	O	Sunscreen Lotion
O	O	Sunburn Gel (Solarcaine®, Aloe Vera, Lip Balm)
O	O	Skin Itch Treatment (Calamine Lotion)
O	O	Calcium Carbonate (Tums®)
O	O	Magnesium Sulfate (Epsom Salts®)
O	O	Midol (Females only)

WAIVER: In consideration of the benefits to be derived, in view of the fact that participation in Scouting Activities is voluntary, and having full confidence that reasonable precautions will be taken for my Scout's safety and well being, I agree to their participation in Scouting Activities and waive all claims against the leaders of the Order of the Arrow, BSA Scouting Activity, and/or its sponsor. I have provided the Denver Area Council with current and accurate medical information about my Scout.

Signature (Parent):_____ Date: _____

Print Name (Parent):_____

Emergency Contact Phone Number: _____

Colorado Allergy and Anaphylaxis Emergency Care Plan and Medication Orders

Student's Name: _____ D.O.B. _____ Grade: DAC - BSA

School: [illegible] 144 Teacher: [illegible]

ALLERGY TO: _____

HISTORY: _____

_____

Place child's photo here

Asthma: ☐ YES (higher risk for severe reaction) – refer to their asthma care plan

☐ NO

To be completed by healthcare provider

◊ STEP 1: TREATMENT

SEVERE SYMPTOMS: Any of the following:

LUNG: Short of breath, wheeze, repetitive cough
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Swelling of the tongue and/or lips
HEART: Pale, blue, faint, weak pulse, dizzy
SKIN: Many hives over body, widespread redness
GUT: Vomiting or diarrhea (if severe or combined with other symptoms
OTHER: Feeling something bad is about to happen, Confusion, agitation

→

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
   - Ask for ambulance with epinephrine
   - Tell EMS when epinephrine was given
3. Stay with child and
   - Call parent/guardian and school nurse
   - If symptoms don't improve or worsen give second dose of epi if available as instructed below
   - Monitor student; keep them lying down. If vomiting or difficulty breathing, put student on side

Give other medicine, if prescribed. (see below fo orders) Do not use other medicine in place of epinphrine. **USE EPINEPHRINE**

MILD SYMPTOMS ONLY:

NOSE: Itchy, runny nose, sneezing
SKIN: A few hives, mild itch
GUT: Mild nausea/discomfort

→

1. Stay with child and
   - Alert parent and school nurse
   - Give antihistamine (if prescribed)
2. If two or more mild symptoms present or symptoms progress **GIVE EPINEPHRINE** and follow directions in above box

DOSAGE: **Epinephrine**: inject intramuscularly using auto injector (check one): ☐ **0.3 mg** ☐ **0.15 mg**

☐ If symptoms do not improve ____ minutes or more, or symptoms return, 2nd dose of epinephrine should be given if available

Antihistamine: (brand and dose)_____

Asthma Rescue Inhaler (brand and dose)_____

Student has been instructed and is capable of carrying and self-administering own medication. ☐Yes ☐No

Provider (print) _____ Phone Number: _____

Provider's Signature: _____ Date: _____

◊ STEP 2: EMERGENCY CALLS ◊

1. If epinephrine given, **call 911**. State that an anaphylactic reaction has been treated and additional epinephrine, oxygen, or other medications may be needed.
2. Parent: _____ Phone Number: _____
3. Emergency contacts: Name/Relationship Phone Number(s)
   a. _____ 1) _____ 2) _____
   b. _____ 1) _____ 2) _____

DO NOT HESITATE TO ADMINISTER EMERGENCY MEDICATIONS

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child and, if necessary, contact our health care provider. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices and release the school and personnel from any liability in compliance with their Board of Education policies.

Parent/Guardian's Signature: _____ Date: _____

School Nurse: _____ Date: _____

Staff trained and delegated to administer emergency medications in this plan:

1._____ Room _____

2._____ Room _____

3._____ Room _____

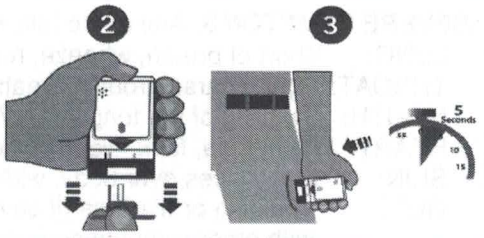
Self-carry contract on file: ☐Yes ☐No

Expiration date of epinephrine auto injector: _____

Keep the child lying on their back. If the child vomits or has trouble breathing, place child on his/her side.

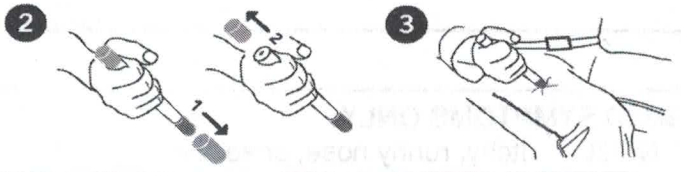
AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3. Place black end against mid-outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.



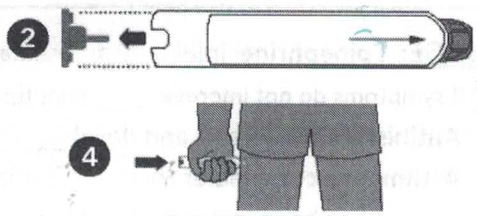
ADRENACLICK® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle enters thigh.
5. Hold in place for 10 seconds. Remove from thigh.



EPIPEN® AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the clear carrier tube.
2. Remove the blue safety release by pulling straight up without bending or twisting it.
3. Swing and firmly push orange tip against mid-outer thigh until it 'clicks'.
4. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove auto-injector from the thigh and massage the injection area for 10 seconds.



If this conditions warrents meal accomodations from food service, please complete the form for dietary disabilitiy if required by district policy.

Additional information:_____

_____

_____

_____

Adopted from the Allergy and Anaphylaxis Emergency Plan provided by the American Academy of Pediatrics, 2017

COLORADO ASTHMA CARE PLAN AND MEDICATION ORDER FOR SCHOOL AND CHILD CARE SETTINGS

PARENT/GUARDIAN COMPLETE AND SIGN:

School/grade: DAC- BSA

Child Name: _____ Birthdate: _____

Parent/Guardian Name: _____ Phone: _____

Healthcare Provider Name: _____ Phone: _____

Triggers: ☐Weather (cold air, wind) ☐Illness ☐Exercise ☐Smoke ☐Dust ☐Pollen ☐Other: _____

☐Life threatening allergy, specify: _____

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child/youth, and if necessary, contact our healthcare provider. I assume full responsibility for providing the school/program prescribed medication and supplies, and to comply with board policies, if applicable. I am aware 911 may be called if a quick relief inhaler is not at school and my child/youth is experiencing symptoms. I approve this care plan for my child/youth.

PARENT SIGNATURE	DATE	NURSE/CCHC SIGNATURE	DATE

HEALTHCARE PROVIDER COMPLETE ALL ITEMS, SIGN AND DATE:		QUICK RELIEF (RESCUE) MEDICATION: ☐ Albuterol ☐ Other: _____ Common side effects: ↑ heart rate, tremor ☐ Have child use spacer with inhaler. Controller medication used at home: _____
	IF YOU SEE THIS:	**DO THIS:**
GREEN ZONE: No Symptoms Pretreat	• No current symptoms • Doing usual activities	Pretreat strenuous activity: ☐ Not required ☐ Routine ☐ Student/Parent request Give QUICK RELIEF MED 10-15 minutes before activity: ☐ 2 puffs ☐ 4 puffs ☐ Repeat in 4 hours, if needed for additional physical activity. ***If child is currently experiencing symptoms, follow YELLOW ZONE.***
YELLOW ZONE: Mild symptoms	• Trouble breathing • Wheezing • Frequent cough • Complains of tight chest • Not able to do activities, but talking in complete sentences • Peak flow: _____ & _____	1. Stop physical activity. 2. Give QUICK RELIEF MED: ☐ 2 puffs ☐ 4 puffs 3. Stay with child/youth and maintain sitting position. 4. **REPEAT** QUICK RELIEF MED, if not improving in 15 minutes: ☐ 2 puffs ☐ 4 puff 5. Child/youth may go back to normal activities, once symptoms are relieved. 6. Notify parents/guardians and school nurse. ***If symptoms do not improve or worsen, follow RED ZONE.***
RED ZONE: EMERGENCY Severe Symptoms	• Coughs constantly • Struggles to breathe • Trouble talking (only speaks 3-5 words) • Skin of chest and/or neck pull in with breathing • Lips/fingernails gray or blue • ↓ Level of consciousness • Peak flow < _____	1. Give QUICK RELIEF MED: ☐ 2 puffs ☐ 4 puffs ▪ Refer to anaphylaxis plan, if child/youth has life-threatening allergy. 2. Call 911 and inform EMS the reason for the call. 3. Stay with child/youth. Remain calm, encouraging slower, deeper breaths. 4. Notify parents/guardians and school nurse. 5. If symptoms do not improve, **REPEAT** QUICK RELIEF MED: ☐ 2 puffs ☐ 4 puffs every 5 minutes until EMS arrives. *School personnel should not drive student to hospital.*

PROVIDER INSTRUCTIONS FOR QUICK RELIEF INHALER USE: CHECK APPROPRIATE BOX(ES)

☐ Student needs supervision or assistance to use inhaler. Student will not self-carry inhaler.

☐ Student understands proper use of asthma medications, and in my opinion, can carry and use his/her inhaler at school independently with approval from school nurse and completion of contract.

☐ Student will notify school staff after using quick relief inhaler, if symptoms do not improve with use.

HEALTH CARE PROVIDER SIGNATURE	PRINT PROVIDER NAME	DATE	FAX	PHONE

Copies of plan provided to: ☐Teacher(s) ☐PhysEd/Coach ☐Principal ☐Main Office ☐Bus Driver Other_____

COLORADO Department of Education

Revised: March 2018

Tahosa Lodge, Scouts BSA
Contract to Carry / Self Administer Medication

*This contract is intended for Scouts diagnosed with **asthma, anaphylaxis, severe allergies and/or other life-threatening conditions** and is in effect while in Camp*

Scout Name:_____ **Date of Birth:**_____

Medication:_____

Purpose of Medication:_____

Scout:

- I agree to keep my medication with me while at camp and use it in a responsible manner
- I will notify camp first aid staff when I use my medication
- I will notify camp first aid staff immediately if my condition for which I am prescribed my medication presents any unusual difficulty or symptoms
- I will not allow any other scout to administer or use my medication
- I understand that if I fail to comply with this contract, my privilege to carry/self administer the medication may be withdrawn

Scout Signature:_____ Date:_____

Parent or Guardian:

- I assure that my child will carry his/her medication as prescribed, the medication will be appropriately labeled by a pharmacist or healthcare provider and the medication is not expired
- I will assure that back up medication is provided to camp first aid staff for emergencies

Parent Signature:_____ Date:_____

Camp First Aid Staff

- I will ensure that the child can demonstrate correct technique for self administering medication
- I will assure that child has understanding of the proper time and dose for self administering medication
- I agree that appropriate camp staff will be notified of the child's condition and that they are carrying medication

First Aid Staff Signature:_____ Date:_____

IMMUNIZATION EXEMPTION REQUEST

SOLICITUD DE EXENCIÓN DE INMUNIZACIÓN

On religious, philosophical, or medical grounds, I request exemption for ☐ me and/or ☐ my child from all vaccinations and/or immunizations required by the BSA (found on Scouting.org under Scouting Safely) for attendance to Camp _____ operated by the _____ Council, Boy Scouts of America. I understand that a medical evaluation and screening by a licensed health-care practitioner is necessary to reduce the possibility of exposing other camp participants to a communicable disease.

In consideration of these exemptions, I understand that I accept complete responsibility for the health of ☐ me and/or ☐ my child, and I hereby release and agree to hold harmless the Boy Scouts of America and any of its officers, agents, and representatives from any liability that might arise during Scouting activities by virtue of this exemption. It is further understood that, should an emergency arise, (name)_____, (telephone) _____, will be notified immediately. In the event that this contact cannot be located immediately, the Boy Scouts of America authorities may take such temporary measures as they deem necessary.

Por motivos religiosos, filosóficos o médicos, solicito la exención para mí ☐ o mi hijo ☐ de todas las vacunas o inmunizaciones requeridas por BSA (que se encuentran en Scouting.org bajo Scouting Safely) para asistir al campamento _____, operado por el concilio _____, Boy Scouts of America. Entiendo que una evaluación médica y el examen por parte de un profesional de la salud con licencia son necesarios para reducir la posibilidad de exponer a otros participantes del campamento a una enfermedad transmisible.

En consideración a estas exenciones, entiendo que acepto completa responsabilidad por mi salud ☐ o la de mi hijo ☐ y por medio de la presente libero y acuerdo eximir a la organización Boy Scouts of America y a cualquiera de sus funcionarios, agentes y representantes de cualquier responsabilidad que pueda surgir durante las actividades Scouting en virtud de esta exención. Queda entendido asimismo que, si surge una emergencia, (nombre) _____, (teléfono)_____, será notificado inmediatamente. En caso de que este contacto no sea localizado inmediatamente, las autoridades de Boy Scouts of America podrán tomar las medidas temporales que consideren necesarias.

_____

Participant signature
Firma del participante

_____

Parent/guardian signature
Firma del padre/tutor

_____

Date
Fecha

_____

Name (print)
Nombre (con letra)

_____

Address
Dirección

_____

City, State, Zip
Ciudad, Estado, Código postal

BOY SCOUTS OF AMERICA®

680-451
2012 Printing

Copy front and back side of medical insurance card onto this sheet

This card is for (Scout Name):_____

FRONT OF CARD

BACK OF CARD

Model COVID-19 Pre-Event Medical Screening Checklist

Use this checklist to assist in identifying potential COVID-19 cases before event participation.

Review with each youth and adult participant their current health status, both before departure and upon arrival at the event. **Anyone entering a camp or event – including visitors, vendors, etc. – must be screened.**

Councils should customize with input from their council health supervisor and local health department.

❑ Yes ❑ No Have you or has anyone in your household been in close contact* in the past 14 days with anyone known or suspected to have COVID-19 or is otherwise sick?

❑ Yes ❑ No Have you or has anyone in your household been in close contact* with anyone who has been tested for COVID-19 and is waiting for results?

❑ Yes ❑ No Have you or has anyone in your household been sick in the past 14 days, or have you or they been tested for any illness and are waiting for results?

❑ Yes ❑ No Has anyone in your household been exposed to an individual known or suspected to have COVID-19 in the past 14 days?

❑ Yes ❑ No Have you or has anyone you have been in close contact* with traveled on a cruise ship or internationally or to an area with a known communicable disease outbreak in the past 14 days?

According to the Centers for Disease Control and Prevention (CDC), "close contact" means:

- You were within 6 feet of someone who has COVID-19 for a cumulative total of 15 minutes or more over a 24-hour period
- You had direct physical contact with an infected person (hugged or kissed them)
- You shared eating or drinking utensils
- An infected person sneezed, coughed, or otherwise got respiratory droplets on you

If the answer is* YES *to any one of the five questions above, the participant must stay home.

If all answers above are* NO*, proceed to the symptoms list below.

Symptoms of COVID-19

*If anyone in your household has **any one** of the following new or worsening signs or symptoms of possible COVID-19, **the entire household must stay home.***

- ❑ **Shortness of breath**
- ❑ **Cough**
- ❑ **Fever of 100.0º or greater**
- ❑ **Flu-like symptoms**
- ❑ **Repeated shaking with chills**
- ❑ **Fatigue**
- ❑ **Muscle or body aches**
- ❑ **Headache**
- ❑ **Sore throat**
- ❑ **Loss of taste or smell**
- ❑ **Diarrhea**
- ❑ **Nausea or vomiting**

*Potential Higher-Risk Individuals**

❑ Yes ❑ No Are you in a higher-risk category as defined by the CDC guidelines, including older adults, people with medical conditions, and those with other individual circumstances?

If the answer is "yes," we recommend that you stay home.
Should you choose to participate, you must have approval from your health care provider.