PERSONAL HEALTH AND MEDICAL RECORD FORM—Class 3

I. IDENTIFICATION Age 16 Sex M Date of Birth* 05 23 91 (Mo. Day Year)

Name Sclawy-Adelman, Michael B (Last name, First name, Initial)
Address 1262 CROSSBILL CT
City & State WESTON, FL Zip 33327
Health/Accident Insurance MEMORIAL HEALTH CARE SYSTEM Policy no. 991043079

IN AN EMERGENCY NOTIFY:
Name JUDITH SCLAWY Relationship MOTHER
Address 1262 CROSSBILL CT. Home phone 954 389 5887
City & State WESTON FL 33327 Business phone 954 554 4281
Personal Physician DR. FLIEGENSPAN Phone 954 389 7000

BOY SCOUTS OF AMERICA
All Class 3 activities require a health examination within the past 12 months by a licensed health-care practitioner.* This includes youth and adult members participating in high-adventure activities, athletic competition, and world jamborees. Annually, this form is to be used by adults 40 years of age or older for all activities requiring a physical examination and applies to *all* Wood Badge participants/staff regardless of age.

II. EMERGENCY MEDICAL INFORMATION
Has or is subject to (check and give details):
- [x] Allergy to a medicine, food†, plant, animal, or insect toxin PEDIAZOLE
- [ ] Any condition that may require special care, medication, or diet
- [ ] ADHD (Attention Deficit Hyperactive Disorder)
- [ ] Asthma [ ] Convulsions [ ] Heart trouble [ ] Contact lenses
- [ ] Diabetes† [ ] Fainting spells [ ] Bleeding disorders [ ] Dentures

EXPLAIN

PLEASE TYPE OR PRINT.

NAME MICHAEL SCLAWY-ADELMAN UNIT TROOP # 111

NOTE: Keep original form for your personal record. Make reproductions for agency use. Be sure information and signatures are legible on reproduced copies. This upper section may be reproduced and carried with you for emergency identification and care.

III. PARENTAL STATEMENT
Has it ever been necessary to restrict applicant's activities for medical reasons? [x] No [ ] Yes / Does applicant take medicine regularly or have special care? [x] No [ ] Yes If yes, explain.

To the best of my knowledge, the information in sections I, II, III, IV, and VI is accurate and complete. I request a licensed health-care practitioner to examine applicant, to give needed immunization, and to furnish requested information to other agencies as needed. I give my permission for full participation in BSA programs, subject to limitations noted herein. In the event of illness or accident in the course of such activity, I request that measures be instituted without delay as judgment of medical personnel dictates.

Parent or guardian J. Sclawy (Must sign if applicant is 18 or younger)
Applicant's signature
Date signed 5/17/08
Updated 5/17/08 Signed J. Sclawy (Parent or guardian)
Updated ____ Signed ____ (Parent or guardian)

IV. IMMUNIZATIONS
If disease, put "D" and year.

	Last year given
Tetanus	
Diphtheria	
Pertussis	
Measles	
Mumps	
Rubella	
Polio	
Chicken Pox	

Religious preference

V. LICENSED HEALTH-CARE PRACTITIONER'S EVALUATION AND ADVICE
Approved for participation in:
- [ ] Hiking and camping [ ] Water activities
- [ ] Competitive sports [x] All activities

Specify exceptions
Recommendations (explain any restrictions OR limitations):

Signed [signature] (Licensed health-care practitioner) Date 5/13/08

*Examinations conducted by licensed health-care practitioners other than physicians will be recognized for BSA purposes in those states where they are licensed to perform physical examinations within their scope of practice.

[Stamp: ... Pediatric Associates ... 1835 N. Corporate Lakes Blvd. ... FL 33326]

VI. MEDICAL HISTORY

Parent (or applicant if 18 or older): Fill in sections I, II, III, IV, and VI *before seeing a licensed health-care practitioner.* Check immunizations to be given at this time. Be sure to include any emergency information and restrictions or special care that should be observed. Especially be sure to record *any* injuries, illnesses, surgery, or significant changes in condition of health of applicant since last complete examination.

- Date of most recent complete physical examination (month and year) 5/17 20 08
- Are you aware of any current health problems? [x] No [ ] Yes
- Now under medical care or taking medicines? [x] No [ ] Yes
- Has there been any surgery, injury, illness, allergy, or change in health status since last complete physical examination? [x] No [ ] Yes

Give dates and full details below for any "yes" answers.

IS THERE DISEASE OF (OR PAST OR PRESENT HISTORY OF):	No	Yes	Year	Details/Medicines
Serious illness	✓			
Serious injury	✓			
Deformity	✓			
Surgery	✓			
Skin, glands	✓			
Ears, eyes	✓			
Nose, sinus	✓			
Teeth, tonsils	✓			
Dentures	✓			
Bridge	✓			
Chest, lungs	✓			
Heart	✓			
Murmur	✓			
Rheumatic fever	✓			
Stomach, bowels	✓			
Appendicitis	✓			
Kidneys or urine	✓			
Albumin	✓			
Sugar	✓			
Infection	✓			
Bed-wetting	✓			
Menstrual problems	✓			
Hernia (rupture)	✓			
Back, limbs, joints	✓			
Sleepwalking	✓			
Nervous condition	✓			
Other (explain)	✓			

Please list ALL medications taken in the 30 days prior to arrival at the Scouting activity where this form is to be used:
CLARITIN-D

VII. HEALTH EXAMINATION
Licensed Health-Care Practitioner:

The applicant will be participating in a strenuous activity that will include one or more of the following conditions: athletic competition, adventure challenge or wilderness expedition (afoot or afloat) that may include high altitude, extreme weather conditions, cold water, exposure, fatigue, and/or remote conditions where ready available medical care cannot be assured.

- Please insist applicant furnish complete medical history (VI) before exam.
- Review immunizations; for youth (18 or younger) tetanus and diphtheria toxoids, measles, mumps, and rubella vaccines, and trivalent oral polio vaccine are required; youths and adults must have had tetanus booster within 10 years. A measles booster is recommended at age 12.
- After completing section VII, summarize any restrictions and/or recommendations in sections II and V, above, and sign.

Date 5/13/08 Ht. 6'3" Wt. 220 B.P. 123/71 Pulse 114
VISION: Normal ____ Glasses ✓ Contacts ____
HEARING: Normal ✓ Abnormal ____

Check box if normal; circle if abnormal and give details below:
- [x] Growth, development [x] Teeth, tonsils [x] Genitourinary
- [x] Skin, glands, hair [x] Respiratory [x] Skeletomuscular
- [x] Head, neck, thyroid [x] Cardiovascular [x] Neuropsychiatric
- [x] Eyes, ears, nose [x] Abdomen, hernia, rings [ ] Other (specify)

COMMENTS

FOR THOSE ATTENDING PHILMONT OR NATIONAL HIGH-ADVENTURE BASES:
* The minimum age for all participants is 13 by January 1 of the year of participation, or have completed the seventh grade. No exceptions.

† Trail food is by necessity a high-carbohydrate, high-calorie diet. It is high in wheat, milk products, sugar, corn syrup, and artificial coloring/flavoring. Dinner meals contain meat. If these food products cause a problem in your diet, you need to bring appropriate substitutions with you and so advise base personnel.

Note: Licensed health-care practitioners representing high-adventure bases reserve the right to deny access to the trails or other program activity on the basis of a medical evaluation performed at the base after arrival.

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