PERSONAL HEALTH AND MEDICAL RECORD FORM—Class 3

I. IDENTIFICATION

Age 16 Sex M

Name Sclawy-Adelman, Michael B (Last name, First name, Initial)

Date of Birth* 05 29 91 (Mo. Day Year)

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 5387

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.

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.

II. EMERGENCY MEDICAL INFORMATION

Has or is subject to (check and give details):

☑ 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

III. PARENTAL STATEMENT

Has it ever been necessary to restrict applicant's activities for medical reasons? ☑ No ☐ Yes Does applicant take medicine regularly or have special care? ☑ 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 ☑ All activities

Specify exceptions

Recommendations (explain any restrictions OR limitations)

Date 5/17/08

Signed ______ *Licensed health-care practitioner

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

Jeffrey B. Fliegenspan, M.D.
Pediatric Associates
1835 N. Corporate Lakes Blvd
Weston, 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? ☑ No ☐ Yes
- Now under medical care or taking medicines? ☑ No ☐ Yes
- Has there been any surgery, injury, illness, allergy, or change in health status since last complete physical examination? ☑ 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

34412B

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 readily 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. 65 3/4 Wt. 220

B.P. [illegible] Pulse 114

VISION: Normal ______ Glasses ✓ Contacts ______

HEARING: Normal ✓ Abnormal ______

Check box if normal; circle if abnormal and give details below:

☑ Growth, development ☑ Teeth, tonsils ☑ Genitourinary

☑ Skin, glands, hair ☑ Respiratory ☑ Skeletomuscular

☑ Head, neck, thyroid ☐ Cardiovascular ☐ Neuropsychiatric

☐ Eyes, ears, nose ☐ 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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DEFENDANT'S EXHIBIT
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