Learning for Life Annual Health and Medical Record

(Valid for 12 calendar months)

Policy on Use of the Learning for Life Annual Health and Medical Record

In order to provide better care for its members and to assist them in better understanding their own physical capabilities, Learning for Life recommends that everyone who participates in a Learning for Life event have an annual medical evaluation by a certified and licensed health-care provider—a physician (MD or DO), nurse practitioner, or physician assistant. Providing your medical information on this form will help ensure you meet the minimum standards for participation in various activities. Note that adult leaders must always protect the privacy of unit participants by protecting their medical information.

Parts A and B are to be completed at least annually by participants in all Learning for Life events. This health history, parental/guardian informed consent and hold harmless/release agreement, and talent release statement is to be completed by the participant and parents/guardians.

Part C is the physical exam that is required for participants in any event that exceeds 72 consecutive hours or when the nature of the activity is strenuous and demanding. Service projects or work weekends may fit this description. Part C is to be completed and signed by a certified and licensed heath-care provider—physician (MD or DO), nurse practitioner, or physician assistant. It is important to note that the height/weight limits must be strictly adhered to when the event will take the post more than 30 minutes away from an emergency vehicle, accessible roadway, or to remote areas.

Risk Factors

Based on the vast experience of the medical community, Learning for Life has identified that the following risk factors may define your participation in various outdoor activities.

- Excessive body weight
- Heart disease
- Hypertension (high blood pressure)
- Diabetes
- Seizures
- Lack of appropriate immunizations
- Asthma
- Allergies/anaphylaxis
- Muscular/skeletal injuries
- Psychiatric/psychological and emotional difficulties

For more information on medical risk factors, visit the Safety First Guidelines on www.learningforlife.org.

Prescriptions

The taking of prescription medication is the responsibility of the individual taking the medication and/or that individual's parent or guardian. An adult leader, after obtaining all the necessary information, can agree to accept the responsibility of making sure a youth takes the necessary medication at the appropriate time, but Learning for Life does not mandate or necessarily encourage the leader to do so. Also, if state laws are more limiting, they must be followed.

Annual Learning for Life 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. _____

Adult leader _____ Council name/No. _____ Post No. _____

Social Security No. (optional; may be required by medical facilities for treatment) _____ Religious preference _____

Health/accident insurance company _____ Policy No. _____

ATTACH A PHOTOCOPY OF BOTH SIDES OF INSURANCE CARD. IF FAMILY HAS NO MEDICAL INSURANCE, STATE "NONE."

In case of emergency, notify:

Name _____ Relationship _____

Address _____

Home phone _____ Business phone _____ Cell phone _____

Alternate contact _____ Alternate's phone _____

HEALTH HISTORY

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

Yes	No	Condition	Explain
		Asthma Last attack: _____	
		Diabetes Last HbA1c: _____	
		Hypertension (high blood pressure)	
		Heart disease (e.g., CHF, CAD, MI)	
		Stroke/TIA	
		Lung/respiratory disease	
		Ear/sinus problems	
		Muscular/skeletal condition	
		Menstrual problems (women only)	
		Psychiatric/psychological and emotional difficulties	
		Behavioral disorders (e.g., ADD, ADHD, Asperger syndrome, autism)	
		Bleeding disorders	
		Fainting spells	
		Thyroid disease	
		Kidney disease	
		Sickle cell disease	
		Seizures Last seizure: _____	
		Sleep disorders (e.g., sleep apnea)	Use CPAP: Yes ☐ No ☐
		Abdominal/digestive problems	
		Surgery	
		Serious injury	
		Other	

Allergies or Reaction to:

Medication _____

Food, Plants, or Insect Bites _____

_____

Immunizations:

The following are recommended by Learning for Life. **Tetanus immunization is required and must have been received within the last 10 years.** If had disease, put "D" and the year. If immunized, check the box and the year received.

Yes	No	Date
☐	☐	**Tetanus** _____
☐	☐	Pertussis _____
☐	☐	Diphtheria _____
☐	☐	Measles _____
☐	☐	Mumps _____
☐	☐	Rubella _____
☐	☐	Polio _____
☐	☐	Chicken pox _____
☐	☐	Hepatitis A _____
☐	☐	Hepatitis B _____
☐	☐	Influenza _____
☐	☐	Other (i.e., HIB) _____

☐ Exemption to immunizations claimed (form required).

(For more information about immunizations, as well as the immunization exemption form, see Learning for Life's Safety First Guidelines.)

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 _____ Approximate date started _____ Reason for medication _____ _____	Medication _____ Strength _____ Frequency _____ Approximate date started _____ Reason for medication _____ _____	Medication _____ Strength _____ Frequency _____ Approximate date started _____ Reason for medication _____ _____
Medication _____ Strength _____ Frequency _____ Approximate date started _____ Reason for medication _____ _____	Medication _____ Strength _____ Frequency _____ Approximate date started _____ Reason for medication _____ _____	Medication _____ Strength _____ Frequency _____ Approximate date started _____ Reason for medication _____ _____

Administration of the above medications is approved by (if required by your state): _____/_____
Parent/guardian signature and/or MD/DO, NP, or PA signature

Be sure to bring medications in sufficient quantities and the original containers. Make sure that they are NOT expired, including inhalers and EpiPens. You SHOULD NOT STOP taking any maintenance medication.

Full name: _____ DOB: _____ Allergies: _____ Emergency contact No.: _____

Part B

INFORMED CONSENT AND HOLD HARMLESS/RELEASE AGREEMENT

I understand that participation in Learning for Life activities involves a certain degree of risk. I have carefully considered the risk involved and have given consent for myself and/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 Learning for Life, 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 Learning for Life volunteers and professionals who need to know of medical situations that might require special consideration for the safe conducting of Learning for Life 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) _____

_____

TALENT RELEASE AGREEMENT

I hereby assign and grant to Learning for Life the right and permission to use and publish the photographs/film/videotapes/electronic representations and/or sound recordings made of me or my child by Learning for Life, and I hereby release Learning for Life from any and all liability from such use and publication.

I hereby 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 Learning for Life, and I specifically waive any right to any compensation I may have for any of the foregoing.

☐ Yes ☐ No

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 _____
2. Name _____
3. Name _____

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 _____ Date _____

Parent/guardian's signature _____ Date _____
(if participant is under the age of 18)

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

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

Part C

TO THE EXAMINING HEALTH-CARE PROVIDER (Certified and licensed physicians [MD, DO], nurse practitioners, and physician's assistants)

You are being asked to certify that this individual has no contraindication for participation in a Learning for Life experience.

PHYSICAL EXAMINATION

Height (inches) _____ Weight (pounds)_____ Maximum weight for height _____ Meets height/weight limits ☐ Yes ☐ No
Blood pressure _____ Pulse _____ Percent body fat (optional)_____

If you exceed the maximum weight for height as explained on this page and your planned activity will take you more than 30 minutes away from an emergency vehicle–accessible roadway, you **will not** be allowed to participate. At the discretion of the medical advisors of the event and/or camp, participation of an individual exceeding the maximum weight for height may be allowed if the body fat percentage measured by the health-care provider is determined to be 20 percent or less for a female or 15 percent or less for a male. Please call the event leader and/or camp if you have any questions. Enforcing the height/weight guidelines is strongly encouraged for all other events.

	Normal	Abnormal	Explain Any Abnormalities	Range of Mobility	Normal	Abnormal	Explain Any Abnormalities
Eyes				Knees (both)			
Ears				Ankles (both)			
Nose				Spine			
Throat							
Lungs							
Neurological				**Other**	**Yes**	**No**	
Heart				Contacts			
Abdomen				Dentures			
Genitalia				Braces			
Skin				Inguinal hernia			**Explain**
Emotional adjustment				Medical equipment (i.e., CPAP, oxygen)			
Tuberculosis (TB) skin test (if required by your state for camp staff) ☐ Negative ☐ Positive							

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

_____

Restrictions (if none, so state) _____

_____

EXAMINER'S CERTIFICATION

I certify that I have reviewed the health history and examined this person and find no contraindications for participation in a Learning for Life experience. This participant (with noted restrictions above)

True False

- ☐ ☐ Meets height/weight requirements
- ☐ ☐ Does not have uncontrolled heart disease, asthma, or hypertension
- ☐ ☐ Has not had an orthopedic injury, musculoskeletal problems, or orthopedic surgery in the last six months or possesses a letter of clearance from their orthopedic surgeon or treating physician
- ☐ ☐ Has no uncontrolled psychiatric disorders
- ☐ ☐ Has had no seizures in the last year
- ☐ ☐ Does not have poorly controlled diabetes
- ☐ ☐ If less than 18 years of age and planning to scuba dive, does not have diabetes, asthma, or seizures

Provider printed name _____

Address _____

City, state, zip _____

Office phone _____

Signature _____

Date _____

Height (inches)	Recommended Weight (lbs)	Allowable Exception	Maximum Acceptance
60	97-138	139-166	166
61	101-143	144-172	172
62	104-148	149-178	178
63	107-152	153-183	183
64	111-157	158-189	189
65	114-162	163-195	195
66	118-167	168-201	201
67	121-172	173-207	207
68	125-178	179-214	214
69	129-185	186-220	220
70	132-188	189-226	226
71	136-194	195-233	233
72	140-199	200-239	239
73	144-205	206-246	246
74	148-210	211-252	252
75	152-216	217-260	260
76	156-222	223-267	267
77	160-228	229-274	274
78	164-234	235-281	281
79 & over	170-240	241-295	295

This table is based on the revised Dietary Guidelines for Americans from the U.S. Dept. of Agriculture and the Dept. of Health & Human Services.

DO NOT WRITE IN THIS BOX

REVIEW FOR CAMP OR SPECIAL ACTIVITY
Reviewed by _____ Date _____
Further approval required ❑ Yes ❑ No Reason _____
By _____ Date _____

Part C **Full name:** _____ **DOB:** _____

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