

# **Annual Health and Medical Record**

(Valid for 12 calendar months)

## **Medical Information**

Learning for Life recommends that all youth and adult members have annual medical evaluations by a certified and licensed health-care provider. In an effort to provide better care to those who may become ill or injured and to provide youth members and adult leaders a better understanding of their own physical capabilities, Learning for Life has established minimum standards for providing medical information prior to participating in various activities. Those standards are offered below in one three-part medical form. Note that volunteer leaders must always protect the privacy of participants by protecting their medical information.

Parts A and C are to be completed annually by all Learning for Life participants. Both parts are required for all events that do not exceed 72 consecutive hours, where the level of activity is similar to that normally expended at home or at school, such as field days, conferences, and academics, or an overnight camp, and where medical care is readily available. Medical information required includes a current health history and list of medications. Part C also includes the parental informed consent and hold harmless/release agreement (with an area for notarization if required by your state) as well as a talent release statement. Adult leaders should review participants' health histories and become knowledgeable about the medical needs of the youth participants. This form is to be filled out by participants and parents or guardians and kept on file for easy reference.

Part B is required with parts A and C for any event that exceeds 72 consecutive hours, a resident camp setting, or when the nature of the activity is strenuous and demanding, such as service projects or high-adventure treks. It is to be completed and signed by a certified and licensed health-care provider—physician (MD, DO), nurse practitioner, or physician's assistant as appropriate for your state. The level of activity ranges from what is normally expended at home or at school to strenuous activity such as hiking and backpacking. Other examples include law enforcement and firefighting activities, mock trial competitions, and other outdoor activities. It is important to note that the height/weight chart must be strictly adhered to if the event will take the post beyond a radius wherein emergency evacuation is more than 30 minutes by ground transportation.

#### **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
- Sleep disorders
- 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.

Approximate date started

Temporary  $\square$  Permanent  $\square$ 

<b>Annual Learning for</b>	Life Health	and Medical	Record
Part A			

GENERAL II	NFORMATION							
Name		Date of	of birth		Vá	ge	Male □ F	Female [
Address					Gı	rade complet	ted (youth only)	
Dity		State	Zip		Pr	none No		
Adult leader _		Council nan	ne/No			Post N	lo	
	y No. (optional; may be required by me							
	nt insurance company							
realtivaccide	ATTACH A PHOTO	OCOPY OF BOTH SI	DES OF INSURA	NCE CARD (	SEE F			
n coop of o		ILY HAS NO MEDICA	AL INSURANCE,	STATE "NON	E."			
	mergency, notify:		<b>5</b>					
				snip				
Address								
Home phone		Business phone		Cell p	hone			
Alternate cont	act		Alter	nate's phone _				
MEDICAL H	ISTORY							
Are you now,	or have you ever been treated for a	iny of the following:				•	r Reaction to:	
Yes No	Condition		Explain	Medic	cation			
	Asthma			Food,	Plant	s, or Insect E	Bites	
	Diabetes							
	Hypertension (high blood pressu	ure)				Immuniz	zations:	
	Heart disease (i.e., CHF, CAD, I	MI)				•	nended by Learn	•
	Stroke/TIA						ation must have I ) years. If had dis	
	COPD						munized, check	
	Ear/sinus problems					r received.	irriariizea, ericek	t ti lo box
	Muscular/skeletal condition			Yes	No	Date		
	Menstrual problems (women or	nly)						
	Psychiatric/psychological and emotional difficulties					Pertussis _		
	Learning disorders (i.e., ADHD,	ADD)						
	Bleeding disorders	,						
	Fainting spells							
	Thyroid disease							
	Kidney disease						DX	
	Sickle cell disease						·	
	Seizures			—— I		Hepatitis E		
	Sleep disorders (i.e., sleep apne	ea)				Influenza _		
	Gl problems (i.e., abdominal, die					Other		
	Surgery	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			emptio	n to immuniz	zations claimed.	
	Serious injury			(For n	nore ir	nformation al	oout immunizati	ions, as
	Other			well a	s the i	mmunization	exemption form	m, see
AEDICATIO	NC			Learn	ing fo	r Life's Safety	y First Guideline	es. <i>)</i>
MEDICATIO		ional anaca is sas-l-	nd places phate	oony this see	+ of +1-	o hoolth for	m)	
	cations currently used. (If addit EpiPen information must be in						111.)	
	·	1						
-	<u>-</u>	Medication						
	Frequency	Strength					equency	
Reason for r	nedication	Reason for medicati	on	Rea	son to	r medication		
Approximate	data started	Approximate data et	artod	Ann	rovim	ata data stari	ted	
• •	e date started Permanent □	Approximate date st Temporary ☐ Perma				ate date star / □ Permane		
		1						
		Medication		Med	licatio	n		
			_					
	Frequency	Strength Reason for medicati	Frequency	Stre		r medication	equency	

Approximate date started

Temporary  $\square$  Permanent  $\square$ 

Approximate date started

Temporary  $\square$  Permanent  $\square$ 

# Part B

# PHYSICAL EXAMINATION

exceed the we	eight limit as c	would take longer documented at the not mandatory.  Explain Any		
Normal	Abnormal	•		
		Abnormalities		
	L			
Yes	No			
		Explain		
	es 🗆 Climb	icipation in: bing/rappelling enge ("ropes") course		
Provider printed name Signature Address				
Recommended Weight (lbs)				
132-188				
	perform this d name  Recommended Weight (lbs)	pprove this individual for particular g/water activities		

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

Height (inches)	Recommended Weight (lbs)	Allowable Exception	Maximum Acceptance
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.

Part B Last nar	ne:	DOB:
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#### Part C

## 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 Form
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 the 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
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
Parent/guardian's signature
Date
Attach copy of insurance card (front and back) here. If required by your state, use the space provided here for notarization.



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