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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Part C: Pre-Participation Physical

C

This part must be completed by certified and licensed physicians (MD, DO), nurse practitioners, or physician assistants.

Full name: _____

Date of birth: _____

High-adventure base participants:

Expedition/crew No.: _____

or staff position: _____

You are being asked to certify that this individual has no contraindication for participation in a Scouting experience. For individuals who will be attending a high-adventure program, including one of the national high-adventure bases, please refer to the supplemental information on the following pages or the form provided by your patient. You can also visit www.scouting.org/health-and-safety/ahmr to view this information online.

Please fill in the following information:

	Yes	No	Explain
Medical restrictions to participate	☐	☐	

Yes	No	Allergies or Reactions	Explain
☐	☐	Medication	
☐	☐	Food	

Yes	No	Allergies or Reactions	Explain
☐	☐	Plants	
☐	☐	Insect bites/stings	

Height (inches)	Weight (lbs.)	BMI	Blood Pressure	Pulse
			/	

	Normal	Abnormal	Explain Abnormalities
Eyes	☐	☐	
Ears/nose/throat	☐	☐	
Lungs	☐	☐	
Heart	☐	☐	
Abdomen	☐	☐	
Genitalia/hernia	☐	☐	
Musculoskeletal	☐	☐	
Neurological	☐	☐	
Skin issues	☐	☐	
Other	☐	☐	

Examiner's Certification

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

True	False	Explain
☐	☐	Meets height/weight requirements.
☐	☐	Has no uncontrolled heart disease, lung disease, 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 his or her 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 planning to scuba dive, does not have diabetes, asthma, or seizures.

Examiner's signature: _____ **Date:** _____

Examiner's printed name: _____

Address: _____

City: _____ State: _____ ZIP code: _____

Office phone: _____

Height/Weight Restrictions

If you exceed the maximum weight for height as explained in the following chart and your planned high-adventure activity will take you more than 30 minutes away from an emergency vehicle/accessible roadway, you may not be allowed to participate.

Maximum weight for height:

Height (inches)	Max. Weight	Height (inches)	Max. Weight	Height (inches)	Max. Weight	Height (inches)	Max. Weight
60	166	65	195	70	226	75	260
61	172	66	201	71	233	76	267
62	178	67	207	72	239	77	274
63	183	68	214	73	246	78	281
64	189	69	220	74	252	79 and over	295

High-Adventure Risk Advisory to Health-Care Providers and Parents

Florida Sea Base

Phone: 305-664-4173 Website: www.bsaseabase.org

Sea Base Experience. Sea Base adventures are not risk-free. Participants must follow safety measures and take personal responsibility for their health and safety. Climate conditions include temperatures ranging from 45 to 95 degrees, high humidity, heat indexes reaching 110 degrees, and frequent, sometimes severe tropical weather. Prolonged, rigorous activities include snorkeling, scuba diving, kayaking, canoeing, sailing, hiking, and others.

It is the responsibility of participants, participant parents or guardians, participant health-care teams, and unit leaders to see that each individual—youth or adult—can safely take part in Sea Base adventures.

Adult Participants. It is the role of accompanying adults to ensure youth safety. Because of this, adult participants must arrive in good physical condition and have no medical conditions that could result in diverting the Sea Base staff's attention away from youth participants.

Sea Base participants must be able to

- Swim in a strong manner
- Climb a 6-foot ladder, unassisted, in inclement weather, from the water onto a rocking vessel
- Self-rescue if found overboard in inclement weather

Location. Sea Base adventures are conducted at sea, often far from land, with limited access to emergency services. **Response times can be affected by weather, seas, and location, and can be delayed for hours.** Individuals with medical conditions that require immediate or nearly immediate access to professional medical care should not attend Sea Base.

Right to Refuse. Sea Base reserves the right to deny participation based on health and safety concerns and/or medical history.

Special Needs or Medical Concerns. Any individual with special needs or medical concerns must have an onsite advocate who understands the individual's condition and treatment and who is prepared to provide support to the individual.

Trained Leadership. Each crew is required to have at least one adult who is trained in wilderness first aid and CPR or has a greater professional medical certification. This leader acts as the primary first response until emergency services arrive. There are no on-site facilities for treatment or extended care at Sea Base. Sea Base does not staff professional medical personnel.

Medications. Individuals requiring medication should continue medications as prescribed and bring an appropriate supply. Each crew must develop a plan to secure, lock, and dispense medication.

Allergies. Participants with allergies that may result in severe reactions or anaphylaxis should bring an adequate supply of epinephrine auto-injectors (EpiPen) to last up to three hours.

Recommendations Regarding Chronic Illness and/or Compromised Immune System. Persons with chronic conditions and/or compromised immune systems should seek medical advice and education regarding medical risks associated with harsh marine environments before participating. Individuals with open wounds or who are at risk for chronic illnesses or immune disorders should not attend Sea Base.

Hypertension (High Blood Pressure). Participants should have a blood pressure less than 140/90. Individuals with hypertension should have the condition treated and well-controlled before attending.

Insulin-Dependent Diabetes Mellitus. Diabetes must be well-controlled. Hypoglycemia can lead to unconsciousness and drowning.

- Insulin-dependent persons who have been newly diagnosed or who have undergone changes in delivery systems in the last six months are advised not to participate.
- Persons with diabetes who have had frequent problems and/or hospitalizations should not participate.
- Persons using insulin to control diabetes **will not** be permitted to **scuba dive.**
- Any HbA1c test greater than 7 in the previous 12 months **disqualifies** a person from **scuba diving.**
- Persons under the age of 18 who control their diabetes with exercise and diet (without the aid of medication) and can provide three sequential hemoglobin tests with HbA1c values less than 6 **may** be approved to scuba dive.
- Persons over the age of 18 who control their diabetes with exercise and diet (without the aid of medication) and can provide four HbA1c tests, each with a value less than 7, within the previous 12 months **may** be approved to scuba dive.

Seizures (Epilepsy). Seizures while snorkeling or scuba diving are extremely dangerous and often fatal.

- History of loss of consciousness often precludes snorkeling or scuba diving. Formal consultation with a neurologist and/or cardiologist is required.
- No participant with a history of seizures or taking anti-epileptic medication may **snorkel or scuba dive.**
  —Prospective participants with a history of infant febrile seizures **may be considered for snorkeling or diving** after formal consultation with a neurologist.

Asthma. Asthma must be well-controlled. Persons requiring use of medication and/or an inhaler must bring an ample supply.

- Persons being treated for **asthma (including reactive airway disease) are disqualified from scuba diving.**
- Persons with a history of asthma who have been asymptomatic **and** have not used medications to control asthma for five years or more **may be allowed to scuba dive** if resolution of asthma is specifically confirmed by their physician and includes provocative pulmonary function testing conducted by a pulmonologist.
  —Provocative testing can include exercise, hypertonic saline, a hyperpnea test, etc.

High-Adventure Risk Advisory to Health-Care Providers and Parents

Florida Sea Base

Phone: 305-664-4173 Website: www.bsaseabase.org

Recent Musculoskeletal Injuries and Orthopedic Surgery. Persons with musculoskeletal problems or orthopedic surgeries within the last six months must provide a letter from their treating physician to participate.

Psychological and Emotional Difficulties.
Any condition should be well-controlled without the services of a mental health practitioner. Participants requiring medication must bring an ample supply and take as prescribed for the duration of their trip.

- Many psychotropic medications are not compatible with **scuba diving.**
- Persons taking more than one psychotropic medication **will not be cleared to scuba dive.**
- Persons with anxiety **will not be cleared to scuba dive.**

Weight Limits. Participants must meet BSA height and weight guidelines. Exceptions **may** be made for individuals who do not exceed the BSA height and weight guidelines by more than 20 pounds. Due to rescue equipment weight restrictions, individuals who are 78 inches (6.5 feet) and taller cannot be offered an exception.

Scuba Participants. Persons with conditions listed as severe by the Recreational Scuba Training Council (RSTC) **will not be permitted to scuba dive.** Persons with conditions prohibited by BSA scuba policy **will not be permitted to scuba dive.** Various risk factors may exclude a person from scuba diving, either temporarily or permanently. Risk factors include, but are not limited to, ear and sinus problems, recent surgery, spontaneous pneumothorax, asthma or reactive airway disease, seizure disorders, diabetes, leukemia, sickle-cell disease, pregnancy, panic disorders, active psychosis, certain medications, and narcolepsy.

Closing. Sea Base, BSA is an industry leader in maritime adventures with an excellent safety record. If you have questions regarding medical policies, medical concerns, or medical approval, please contact Sea Base at 305-664-4173.