EXAMPLE FORM ONLY

Part A: Informed Consent, Release Agreement, and Authorization

A

Full name: Clark Powers

Date of birth: 02/03/2010

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.

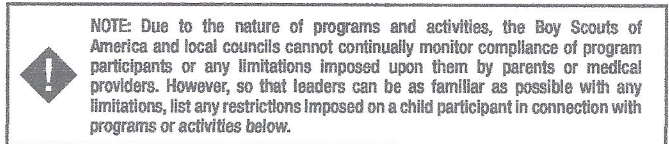
With appreciation of the dangers and risks associated with programs and activities, on my own behalf and/or on behalf of my child, I hereby fully and completely release and waive any and all claims for personal injury, death, or loss that may arise against the Boy Scouts of America, the local council, 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**

Not allowed to yodel

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: Clark Powers Date: 02/15/2025

Parent/guardian signature for youth: Inga Powers Date: 02/15/2025

(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: Super Powers
Phone: 303-317-4397

Name: Supreme Powers
Phone: 303-464-4130

Adults NOT Authorized to Take Youth to and From Events:

Name: ______
Phone: ______

Name: ______
Phone: ______

Part B1: General Information/Health History

B1

Full name: Clark Powers

Date of birth: 02/03/2010

High-adventure base participants:

Expedition/crew No.:

or staff position:

Age: 15 Gender: M Height (inches): 5'7" Weight (lbs.): 150

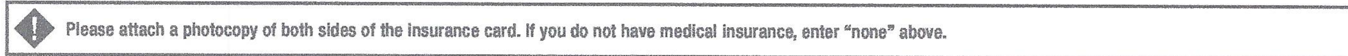
Address: 1234 Purple Stew St

City: Evergreen State: CO ZIP code: 80439 Phone: 303-464-4130

Unit leader: The Amazing Bruce Wayne Unit leader's mobile #: 303-123-4567

Council Name/No.: The Greater Colorado Council Unit No.: 888

Health/Accident Insurance Company: Not the Greatest Insurance Policy No.: 888888888888


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: Grandma Powers Relationship: Grandma

Address: Evergreen, CO Home phone: 303-867-5309 Other phone:

Alternate contact name: Grandpa Powers Alternate's phone: 303-093-5768

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	

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Part B2: General Information/Health History

B2

Full name: Clark Powers

Date of birth: 02/03/2010

High-adventure base participants:

Expedition/crew No.: ______

or staff position: ______

Allergies/Medications

DO YOU USE AN EPINEPHRINE AUTOINJECTOR? Exp. date (if yes) ______ ☐ YES ☒ NO

DO YOU USE AN ASTHMA RESCUE INHALER? Exp. date (if yes) ______ ☐ YES ☒ NO

Are you allergic to or do you have any adverse reaction to any of the following?

Yes	No	Allergies or Reactions	Explain	Yes	No	Allergies or Reactions	Explain
☐	☒	Medication		☐	☒	Plants	
☒	☐	Food	gluten - not good	☐	☒	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: No Exceptions

Administration of the above medications is approved for youth by: [signature] / Dr. Excellent, MD

PARENT SIGNATURE REQUIRED NO MATTER WHAT

DR SIGNATURE REQUIRED IF MEDS ARE REQUIRED

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	02/15/2025
☒	☐		Pertussis	02/15/2025
☒	☐		Diphtheria	02/15/2025
☒	☐		Measles/mumps/rubella	02/15/2025
☒	☐		Polio	02/15/2025
☒	☐		Chicken Pox	02/15/2025
☒	☐		Hepatitis A	02/15/2025
☒	☐		Hepatitis B	02/15/2025
☒	☐		Meningitis	02/15/2025
☒	☐		Influenza	02/15/2025
☒	☐		Other (i.e., HIB)	02/15/2025
☒	☐		Exemption to immunizations **(form required)**	02/15/2025

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.

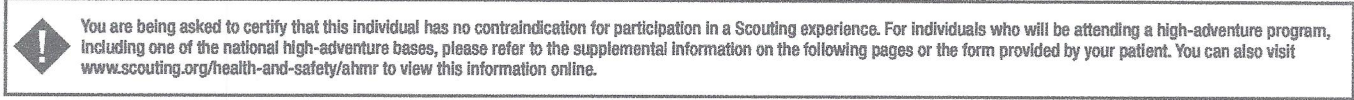
Full name: Clark Powers

Date of birth: 02/03/2010

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	[ ]	[x]	

Yes	No	Allergies or Reactions	Explain
[ ]	[x]	Medication	
[x]	[ ]	Food	gluten
[ ]	[x]	Plants	
[ ]	[x]	Insect bites/stings	

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

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

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
[x]	[ ]	Meets height/weight requirements.
[x]	[ ]	Has no uncontrolled heart disease, lung disease, or hypertension.
[x]	[ ]	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.
[x]	[ ]	Has no uncontrolled psychiatric disorders.
[x]	[ ]	Has had no seizures in the last year.
[x]	[ ]	Does not have poorly controlled diabetes.
[x]	[ ]	If planning to scuba dive, does not have diabetes, asthma, or seizures.

Examiner's signature: Dr. Excellent Date: 02/15/2025

Examiner's printed name: Dr. Excellent

Address: 1234 The Best Rd

City: Evergreen State: CO ZIP code: 80439

Office phone: 303-123-4567

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

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Proof of Insurance

COPY OF FRONT OF MED FORM CARD HERE

Front

COPY OF BACK OF MED FORM CARD HERE

Back

COLORADO LAW REQUIRES THAT THIS FORM BE COMPLETED FOR EACH SCOUT ATTENDING A COLORADO SCOUT CAMP

Name Super Powers ______ Date of Birth ______

Parent/Guardian ______ Dates of the Camp Session ______

COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT CERTIFICATE OF IMMUNIZATION

Vaccine		(Enter the month, day and year each immunization was given.)
Hep B	Hepatitis B	
DTaP	Diphtheria, Tetanus, Pertussis (pediatric)	
DT	Diphtheria, Tetanus (pediatric)	
Tdap	Tetanus, Diphtheria, Pertussis	
Td	Tetanus, Diphtheria	
Hib	*Haemophilus influenzae* type b	
IPV/OPV	Polio	
PCV	Pneumococcal Conjugate	
MMR	Measles, Mumps, Rubella	
Varicella	Chickenpox	Healthcare Provider Documentation Date ______ Lab Verification Date ______

SEE ATTACHED IMMUNIZATION FORM FROM DOCTOR OFFICE

STATEMENT OF EXEMPTION TO IMMUNIZATION LAW

IN THE EVENT OF AN OUTBREAK, EXEMPTED PERSONS MAY BE SUBJECT TO EXCLUSION FROM CAMP AND TO QUARANTINE.

MEDICAL EXEMPTION: The physical condition of the above named person is such that immunization would endanger life or health or is medically contraindicated due to other medical conditions.

Signed ______ Date 02/15/2025
Physician (Medico)

***Medical exemption** to the following vaccine(s):*
La exención por razones médicas aplica a la(s) siguiente(s) vacuna(s):
☐ HepB ☐ DTaP ☐ Tdap ☐ Hib ☐ IPV ☐ PCV ☐ MMR ☐ VAR

RELIGIOUS EXEMPTION: Parent or guardian of the above named person or the person himself/herself is an adherent to a religious belief opposed to immunizations.

Signed ______ Date ______
Parent, guardian, emancipated Scout/counseling minor

***Religious exemption** to the following vaccine(s):*
Exención por motivos religiosos de la(s) siguiente(s) vacuna(s):
☐ HepB ☐ DTaP ☐ Tdap ☐ Hib ☐ IPV ☐ PCV ☐ MMR ☐ VAR

PERSONAL EXEMPTION: Parent or guardian of the above named person or the person himself/herself is an adherent to a personal belief opposed to immunizations.

Signed ______ Date ______
Parent, guardian, emancipated Scout/counseling minor

***Personal exemption** to the following vaccine(s):*
Exención por creencias personales de la(s) siguiente(s) vacuna(s):
☐ HepB ☐ DTaP ☐ Tdap ☐ Hib ☐ IPV ☐ PCV ☐ MMR ☐ VAR

PARENT/GUARDIAN AUTHORIZATIONS

Parent/Guardian Name ______
Parent/Guardian Address ______
Parent/Guardian Telephone Day ______
Eve ______ Cell ______
Place of Employment ______
Address ______
Phone # 303-317-4397

Parent/Guardian Name ______
Parent/Guardian Address ______
Parent/Guardian Telephone Day ______
Eve ______ Cell ______
Place of Employment ______
Address ______
Phone # ______

Individual authorized to take the Scout from camp if different from the parent or guardian:
Name ______ Address ______ City Evergreen ST ____ Zip ______
Phone # Day ______ Eve ______ Cell ______

I hereby authorize the above named person to participate in all special trips or excursions in which the Scout may be walking or riding away from the campsite.
Parent/Guardian/Custodial Adult ______ Date ______

The above named person is restricted from the activities listed below:

______

Parent/Guardian/Custodial Adult ______ Date ______

PARTICIPANT NAME: Clark Powers

COLORADO SUMMER CAMP ADDITIONAL REQUIRED INFORMATION

Colorado Addendum – Additional Information

This information is required by the State of Colorado Department of Human Services, Division of Early Learning and Care, Office of Child Care Licensing. Comments about this additional paperwork can be directed to the State of Colorado Department of Human Services, Office of Early Childhood at 303-866-5948 or cdhs_oec_communications@state.co.us.

ALL INFORMATION MUST BE FILLED OUT ENTIRELY

Specific dates you child is attending camp. *(Child Care Regulation 7.711.41.A.5)*	Dates:
Please list the contact information for the parent or legal guardian. *(Child Care Regulation 7.711.411.A.2)*	Name: Super Powers Relationship: mother Home Address: 1234 Purple Stew St. Evergreen, CO 80439 Work Address: 5678 Busy Work Dr. Denver, CO 80202 Phone Number: 303-464-4130 Email Address: superpowers@gmail.com
Authorized Person(s) allowed to take the child from camp if the parent or guardian is unavailable. *(Consider listing the **adult leaders doing transportation to and from camp**, and another emergency contact. Attach additional sheets as needed. Unless someone is listed, the parent/guardian must pick up the child from camp.)* *(Child Care Regulation 7.711.411.A.4)*	Name: Super Scoutmaster Relationship: scoutmaster Phone Number: 303-201-9555 Address: 123 Scoutmaster Ln Evergreen, CO 80439 Name: Super Assistant Scoutmaster Relationship: assistant scoutmaster Phone Number: 303-515-2234 Address: 1579 Snowy Dr. Evergreen, CO 80439
Sunscreen Authorization *(Child Care Regulation 7.711.31.O)*	I, Super Powers (print parent/guardian name) **DO** or **DO NOT** (circle one) authorize my child to use and wear sunscreen at camp. I also authorize BSA Health Staff to aid my child in the application of sunscreen if <u>they request it</u> at the camp's health lodge. I understand that if my child needs sunscreen, <u>they can request it</u> at the camp health lodge and it will be a SPF 30 or greater. **I also understand that my child's name needs to be written on the sunscreen bottle they come to camp with.** Signature: Super Powers