

MEDICAL EVALUATION (Class 2)

Physical Examination

NAME _____

Class 2 (required once every 36 months for all participants less than 40 years of age). Activity: Resident camp or any other activity such as backpacking, tour camping, or recreational sports involving events lasting longer than 72 consecutive hours, with level of activity similar to that at home or school. Medical care is readily available. Must have a current Class 1 Personal Health Record attached.

If your child has already had a medical evaluation (**physical examination**) within the last 36 months, a copy of the results of this examination must be attached to the Class 1 Person Health Record. If a copy is not available, a new Class 2 Medical Evaluation (**physical examination**) must be administered by a *licensed health-care practitioner. This medical evaluation (**physical examination**) also is required if your child is currently under medical care, takes a prescribed medication, requires a medically prescribed diet, has had an injury or illness during the past 6 months that limited activity for a week or more, has ever lost consciousness during physical activity, or has suffered a concussion from a head injury, before coming to camp.

NOTE: The Class 2 form is not to be used by adults over 40 or High Adventure participants (Rugged E, Whitsett Sierra, Whitsett High Adventure, Canoe Catalina). The Class 3 form must be used.

*Examinations conducted by licensed health-care practitioners, other than physicians, will be recognized for BSA purposes in those states where such practitioners may perform physical examinations within their legally prescribed scope of practice.

TROOP _____

CLASS 2 MEDICAL EVALUATION (PHYSICAL EXAMINATION by Physician)

Participant Name _____ Age _____

NOTE TO LICENSED HEALTH-CARE PRACTITIONERS*: The person being evaluated will be attending one or more weeks of camp that may include sleeping on the ground and participating in strenuous activities such as hiking, boating, and vigorous group games. Please review the health history with the participant for any interim changes. **Explain any "abnormal" evaluations.**

PHYSICAL EXAMINATION (To be filled out by a licensed health-care practitioner*)

Height _____ Weight _____ BP _____ / _____ Pulse _____

VISION: Normal _____ Glasses _____ Contacts _____

HEARING: Normal _____ Abnormal _____ Explain _____

Checkbox:	N	Abn		N	Abn		N	Abn
Growth development	<input type="checkbox"/>	<input type="checkbox"/>	Teeth	<input type="checkbox"/>	<input type="checkbox"/>	Genitalia	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>	Cardiopulmonary system	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>
HEENT	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Neurobehavioral	<input type="checkbox"/>	<input type="checkbox"/>

Explain: _____

Limitations

Activity restrictions _____

Diet restrictions _____

Name _____
Licensed health-care practitioner*

Address _____ Phone _____

City, State, Zip _____

Signature _____ Date _____
Licensed health-care practitioner*

COUNCIL _____