



COI Parent Information and Medical Form

This form to be used by every youth and adult attending Camp Old Indian regardless of program.

This supplement exists to provide you with information to be used in planning your Camp Old Indian adventure and to assure the health and safety of every participant. Please read each section completely. Each person's health and safety is our number one priority. Camp Old Indian has an excellent health and safety record with countless visitors over the last 75 years. COI strives to minimize risks by emphasizing proper precautions. Each participant is expected to use common sense, have proper clothing, be physically fit, be willing to follow instructions and work as a team with his unit and the camp staff, and take responsibility for his own health and safety.

Camp Mailing Address

Individual's Name
Troop/Crew Number
Camp Old Indian
601 Callahan Mountain Rd.
Travelers Rest, SC 29690

Camp Emergency Phone Number

864-895-8989

This number is absolutely for emergencies only. Do not attempt to contact your child unless an emergency is present.

Visitors at Camp

Parents and family are invited to come to camp Wednesday after 5:00 p.m. to picnic with the Scouts and enjoy a campfire program. Visitors are encouraged to bring a picnic supper, but meals can be arranged for visitors with prior notice to the Dining Hall staff by the unit's leader. The costs is \$5.00 per visitor meal. At 8:00 p.m., everyone is invited to the amphitheater for the O.A. Callout Ceremony and the American Indian Dance Pageant. Visitors other times during the week are prohibited. All individuals residing at Camp Old Indian must be a registered Boy Scout or Venturer or an adult acting in a leadership role with a registered BSA unit at camp.

Early Release of Minors

No camper who is a minor will be released to the custody of an adult other than the legal parent or guardian unless written permission is provided to the camper's unit leader and turned in to camp. If a minor leaves camp prior to check out on Saturday, such written instructions must be provided, and the adult and minor must sign out at the Health Lodge.

Medical and Insurance Policy

The Blue Ridge Council provides a medical/accident policy for its Scouts and leaders. It is a secondary policy and will pay up to the first \$300 (unless no other insurance is available). Non-Blue Ridge Council units must provide their own insurance coverage. In all cases, family insurance is the primary source of coverage, and it will be the responsibility of the child's unit leader and parent/guardian to make any claims for insurance at the time of accident or doctor visit. Unit leaders should be prepared to provide insurance policy numbers to medical personnel. Likewise, family insurance information should be listed on the medical form. Parents will be notified in the event that a minor child has to be taken to the doctor or the hospital.

(OVER)

Camp Old Indian Medical Form Page 2

Medical Form and Physicals

Each participant must complete the attached medical form during the year he or she will be attending camp. Anyone arriving without this form completed and a physical will have to leave camp until an exam can be completed at the participant's own expense.

Instructions for Youth and Adults (under 40) in Regular Programs

Complete sections I, II, III, IV, and VI; these sections provide personal and health history. If a physical has been performed with the last 36 months (3 years) from the date of arrival at camp and if a photocopy is available, attach a copy of the physical and omit sections V and VII of the medical form. Otherwise, secure a physical exam and have medical personnel complete sections V and VII.

Instructions for Youth and Adults taking High Adventure Programs and Adults 40 and Over

High Adventure programs include Rangers, Foothills Trek, and Adventure to Eagle (ATE). Complete sections I, II, III, IV, and VI. These sections provide personal and health history. Secure a physical exam and have medical personnel complete sections V and VII.

What to Bring to Camp—Campers in Regular Programs

- Scout uniform—Scout shirt, Scout shorts, Scout belt, Scout socks, and Scouting t-shirts
- Medical form completed
- extra clothing—socks, underwear, shoes, shorts, long pants
- sweater or jacket
- sleeping bag and pillow
- poncho or rain gear
- swim trunks
- soap, comb, toothbrush, and other personal items
- Scout Handbook or Venturer Handbook*, pens, pencils, notebook with paper
- money for crafts, merit badges, Trading Post
- sunscreen, insect repellent, knapsack
- optional camera with film, flashlight, pocket knife

Do Not Bring sheath knives, electronics, valuables, inappropriate clothing

Ranger and Adventure to Eagle Participants Additional Equipment List

In addition to those items every Scout should bring to camp, be sure to have the following:

- leather gloves for rappelling
- wool socks-2 pr.
- hat or cap
- strap for glasses if worn
- long pants
- water bottle/canteen
- waterproof sunscreen
- nylon windbreaker (to wear on river)
- shoes to get wet/river sandals
- bathing suit
- daypack or small backpack

Optional items are camera, pillow, and extra money.

Pathfinder Participants Additional Equipment List

- Class A and B uniforms
- Scout Handbook*
- backpack for overnigher
- canteen, mess kit, utensils
- small tent-one for every 2 Scouts (Pathfinder I only)
- boots or comfortable shoes for hiking
- personal first aid kit
- ground cloth, pad, and sleeping bag
- pocket knife and flashlight

Camp Old Indian Medical Form Page 3

PERSONAL HEALTH AND MEDICAL RECORD FORM—Class 3

I. IDENTIFICATION Age _____ Sex _____ **SS No.** _____ Date of Birth* _____

Name _____
 Last name First name Initial Mo. Day Year

Address _____

City & State _____ Zip _____

Health/Accident insurance _____ Policy no. _____

IN AN EMERGENCY NOTIFY:

Name _____ Relationship _____

Address _____ Home phone _____

City & State _____ Business phone _____

Personal Physician _____ Phone _____

III. PARENTAL STATEMENT

Has it ever been necessary to restrict applicant's activities for medical reasons? No Yes Does applicant take medicine regularly or have special care? No Yes If yes, explain.

To the best of my knowledge, the information in sections I, II, III, IV, and VI is accurate and complete. I request a licensed health-care practitioner to examine applicant, to give needed immunization, and to furnish requested information to other agencies as needed. I give my permission for full participation in BSA programs, subject to limitations noted herein. In the event of illness or accident in the course of such activity, I request that measures be instituted without delay as judgment of medical personnel dictates.

Parent or guardian _____
 (Must sign if applicant is 18 or younger)

Applicant's signature _____

Date signed _____

BOY SCOUTS OF AMERICA

All Class 3 activities require a health examination within the past 12 months by a licensed health-care practitioner.* This includes youth and adult members participating in high-adventure activities, athletic competition, and world jamborees. Annually, this form is to be used by adults over 40 for all activities requiring a physical examination and applies to *all* Wood Badge participants/staff regardless of age.

II. EMERGENCY MEDICAL INFORMATION

Has or is subject to (check and give details):

Allergy to a medicine, food†, plant, animal, or insect toxin

Any condition that may require special care, medication, or diet

ADHD (Attention Deficit Hyperactive Disorder)

Asthma Convulsions Heart trouble Contact lenses

Diabetes† Fainting spells Bleeding disorders Dentures

EXPLAIN _____

V. LICENSED HEALTH-CARE PRACTITIONER'S EVALUATION AND ADVICE

Approved for participation in:

Hiking and camping Water activities

Competitive sports All activities

Specify exceptions _____

Recommendations (explain any restrictions OR limitations): _____

Date _____

Signed _____
 *Licensed health-care practitioner

*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.

PLEASE TYPE OR PRINT.

NAME _____

UNIT _____

NOTE: Keep original form for your personal record. Make reproductions for agency use. Be sure information and signatures are legible on reproduced copies. This upper section may be reproduced and carried with you for emergency identification and care.

VI. MEDICAL HISTORY

Parent (or applicant if 18 or older): Fill in sections I, II, III, IV, and VI *before seeing a licensed health-care practitioner.* Check immunizations to be given at this time. Be sure to include any emergency information and restrictions or special care that should be observed. Especially be sure to record any injuries, illnesses, surgery, or significant changes in condition of health of applicant since last complete examination.

- Date of most recent complete physical examination (month and year) _____ 19____ No Yes
- Are you aware of any current health problems? No Yes
- Now under medical care or taking medicines? No Yes
- Has there been any surgery, injury, illness, allergy, or change in health status since last complete physical examination? No Yes

Give dates and full details below for any "yes" answers.

IS THERE DISEASE OF (OR PAST OR PRESENT) HISTORY OF:

	No	Yes	Year	Details/Medicines
Serious illness	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Serious injury	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Deformity	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Skin, glands	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Ears, eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Nose, sinus	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Teeth, tonsils	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Dentures	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Bridge	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Chest, lungs	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Heart	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Murmur	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Stomach, bowels	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Appendicitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Kidneys or urine	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Albumin	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Sugar	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Infection	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Bed-wetting	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Menstrual problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hernia (rupture)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Back, limbs, joints	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Sleepwalking	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Nervous condition	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Other (explain)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

VII. HEALTH EXAMINATION

Licensed Health-Care Practitioner:

The applicant will be participating in a strenuous activity that will include one or more of the following conditions: athletic competition, adventure challenge or wilderness expedition (afloat or aloft) that may include high altitude, extreme weather conditions, cold water, exposure, fatigue, and/or remote conditions where readily available medical care cannot be assured.

- Please insist applicant furnish complete medical history (VI) before exam.
- Review immunizations; for youth (18 or younger) tetanus and diphtheria toxoids, measles, mumps, and rubella vaccines, and trivalent oral polio vaccine are required; youths and adults must have had tetanus booster within 10 years. A measles booster is recommended at age 12.
- After completing section VII, summarize any restrictions and/or recommendations in sections II and V, above, and sign.

VISION: HEARING:

Date _____ Normal _____ Normal _____

Ht. _____ Wt. _____ Glasses _____ Abnormal _____

B.P. _____ / _____ Pulse _____ Contacts _____

Check box if normal; circle if abnormal and give details below:

<input type="checkbox"/> Growth, development	<input type="checkbox"/> Teeth, tonsils	<input type="checkbox"/> Genitourinary
<input type="checkbox"/> Skin, glands, hair	<input type="checkbox"/> Respiratory	<input type="checkbox"/> Skeletomuscular
<input type="checkbox"/> Head, neck, thyroid	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Neuropsychiatric
<input type="checkbox"/> Eyes, ears, nose	<input type="checkbox"/> Abdomen, hernia, rings	<input type="checkbox"/> Other (specify)

COMMENTS _____

LABORATORY: Urinalysis (Dip stick) Albumin _____ Sugar _____

FOR THOSE ATTENDING PHILMONT OR NATIONAL HIGH-ADVENTURE BASES:

* The minimum age for all participants is 13 by January 1 of the year of participation, or have completed the seventh grade. No exceptions.

† Trail food is by necessity a high-carbohydrate, high-calorie diet. It is high in wheat, milk products, sugar, corn syrup, and artificial coloring/flavoring. Dinner meals contain meat. If these food products cause a problem in your diet, you need to bring appropriate substitutions with you and so advise base personnel.

Note: Licensed health-care practitioners representing high-adventure bases reserve the right to deny access to the trails or other program activity on the basis of a medical evaluation performed at the base after arrival.

Camp Old Indian Medical Form Page 4

(Please Print)

Participant's Name _____ Social Security No. _____

Circle One: Troop Crew Unit Number _____

Special Needs

Please list any special needs or requirements such as diet, allergies, accommodations, etc. Note that every attempt to provide substitute meals will be made, but participants who cannot eat camp food will be required to provide their own.

Parent or Guardian or Adult Participant Certification

I certify that I have read the enclosed information and hereby give permission for myself or my child to participate in the programs at Camp Old Indian except as noted by me.

*I have attached a photocopy of the Insurance Card which covers the participant.
Check here ___ if NO insurance.*

Parent/Guardian or Adult Participant's Signature _____ Date _____

MEDICATION FORM

*This information is mandatory for prescription medications to be taken at camp.
Sufficient quantities must be provided by participant. Photocopy and attach additional pages if necessary.*

- 1.) Medication Name/Strength _____
Dosage _____
Reason for taking _____

Side Effects _____

Storage Requirements _____
Reaction if medication is not taken as directed _____

- 2.) Medication Name/Strength _____
Dosage _____
Reason for taking _____

Side Effects _____

Storage Requirements _____
Reaction if medication is not taken as directed _____

- 3.) Medication Name/Strength _____
Dosage _____
Reason for taking _____

Side Effects _____

Storage Requirements _____
Reaction if medication is not taken as directed _____

Note: All medications must be turned in at the Health Lodge to the medical staff. Exceptions will be made by the Medical Officer for life-threatening conditions requiring medications such as inhalers, bee-sting kits, and heart medications.