



“Catholicism Unplugged” the 2012 Catholic Camporee presented by the Diocese of Jackson Catholic Committee on Scouting will be held February 17-19, 2012. Join Catholic scouts from around the diocese for orienteering, outdoor activities, games, and fellowship. Specific tracks for Cub Scouts and Boy Scouts will provide an opportunity for scouts to reflect upon the movement of God in their lives. Cub Scout activities will focus on “fun with a purpose.” The event will include a presentation of a day-in-the-life of priests/religious and an outdoor mass with Bishop Latino presiding. Call the Diocese of Jackson office at 601-949-6934 to register or more information.

For registration forms, please visit the “Forms” link on the Jackson Diocese Youth Home page.



Catholicism Unplugged

2012 Catholic Camporee
Troop Registration Summary

Troop #: _____

Number of Boy Scouts	_____	x \$20.00 = \$	_____
Number of Adult Leaders	_____	x \$20.00 = \$	_____
Extra Camporee patches	_____	x \$2.00 = \$	_____
Total in Group	_____	Total Due	\$ _____

Checks are payable to: **Catholic Diocese of Jackson**

Mail to: **Kathie Curtis
Office of Youth Ministry
P O Box 2248
Jackson, MS 39225-2248**

Registration deadline is February 7, 2012 in order to procure food for the event.

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Annual Health and Medical Record

(Valid for 12 calendar months)

Policy on Use of the Annual Health and Medical Record

In order to provide better care for its members and to assist them in better understanding their own physical capabilities, the Boy Scouts of America recommends that everyone who participates in a Scouting event have an annual medical evaluation by a certified and licensed health-care provider—a physician (MD or DO), nurse practitioner, or physician assistant. Providing your medical information on this four-part form will help ensure you meet the minimum standards for participation in various activities. Note that unit leaders must always protect the privacy of unit participants by protecting their medical information.

Parts A and B are to be completed at least annually by participants in all Scouting events. This health history, parental/guardian informed consent and hold harmless/release agreement, and talent release statement is to be completed by the participant and parents/guardians.

Part C is the physical exam that is required for participants in any event that exceeds 72 consecutive hours, for all high-adventure base participants, or when the nature of the activity is strenuous and demanding. Service projects or work weekends may fit this description. Part C is to be completed and signed by a certified and licensed health-care provider—physician (MD or DO), nurse practitioner, or physician assistant. It is important to note that the height/weight limits must be strictly adhered to when the event will take the unit more than 30 minutes away from an emergency vehicle-accessible roadway, or when the program requires it, such as backpacking trips, high-adventure activities, and conservation projects in remote areas.

Part D is required to be reviewed by all participants of a high-adventure program at one of the national highadventure bases and shared with the examining health-care provider before completing Part C.

- **Philmont Scout Ranch.** Participants and guests for Philmont activities that are conducted with limited access to the backcountry, including most Philmont Training Center conferences and family programs, will not require completion of Part C. However, participants should review Part D to understand potential risks inherent at 6,700 feet in elevation in a dry Southwest environment. Please review specific registration information for the activity or event.

- **Northern Tier National High Adventure Base.**

- **Florida National High Adventure Sea Base.** The PADI medical form is also required if scuba diving at this base.

Risk Factors

Based on the vast experience of the medical community, the BSA has identified the following risk factors that may limit your participation in various outdoor adventures.

For more information on medical risk factors, visit Scouting Safely on www.scouting.org.

Prescriptions

The taking of prescription medication is the responsibility of the individual taking the medication and/or that individual's parent or guardian. A 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 BSA does not mandate or necessarily encourage the leader to do so. Also, if state laws are more limiting, they must be followed.

Frequently Asked Questions (FAQs)

- Philmont Scout Ranch: www.philmontscoutranch.org or 575-376-2281
- Northern Tier National High Adventure Base: www.ntier.org or 218-365-4811
- Florida National High Adventure Sea Base: www.bsaseabase.org or 305-664-5612
- National Scout Jamboree: www.bsajamboree.org

For frequently asked questions about this Annual Health and Medical Record, see Scouting Safely online at <http://www.scouting.org/scoutsorce/HealthandSafety.aspx>. Information about the Health Insurance Portability and Accountability Act (HIPAA) may be found at <http://www.hipaa.org>.

- Excessive body weight
- Heart disease
- Hypertension (high blood pressure)
- Diabetes
- Seizures
- Lack of appropriate immunizations
- Asthma
- Allergies/anaphylaxis
- Muscular/skeletal injuries
- Psychiatric/psychological and emotional difficulties

High-adventure base participants:

Expedition/crew No.: _____ or staff position: _____

(680-001 2010 Printing Rev. 11/2010)

Full name: _____ **DOB:** _____ **Allergies:** _____

Emergency contact No.: _____

Annual BSA Health and Medical Record

Part A

GENERAL INFORMATION

Name _____ Date of birth _____ Age _____ Male Female
Address _____ Grade completed (youth only) _____
City _____ State _____ Zip _____ Phone No. _____
Unit leader _____ Council name/No. _____ Unit No. _____
Social Security No. (optional; may be required by medical facilities for treatment) _____ Religious preference _____
Health/accident insurance company _____ Policy No. _____

ATTACH A PHOTOCOPY OF BOTH SIDES OF INSURANCE CARD. IF FAMILY HAS NO MEDICAL INSURANCE, STATE "NONE."

In case of emergency, notify:

Name _____ Relationship _____
Address _____
Home phone _____ Business phone _____ Cell phone _____
Alternate contact _____ Alternate's phone _____

HEALTH HISTORY

Are you now, or have you ever been treated for any of the following:

Allergies or Reaction to: Yes/No/Condition/Explain

Medication _____

Food, Plants, or Insect Bites _____

Immunizations:

The following are recommended by the BSA.

Tetanus immunization is required and must have been received within the last 10 years. If had disease, put "D" and the year.

If immunized, check the box and the year received.

Yes/No/Date

Tetanus _____
Pertussis _____
Diphtheria _____
Measles _____
Mumps _____
Rubella _____
Polio _____
Chicken pox _____
Hepatitis A _____
Hepatitis B _____
Influenza _____
Other (i.e., HIB) _____

Exemption to immunizations claimed (form required).

Asthma Last attack: _____
Diabetes Last HbA1c: _____
Hypertension (high blood pressure)
Heart disease (e.g., CHF, CAD, MI)
Stroke/TIA
Lung/respiratory disease
Ear/sinus problems
Muscular/skeletal condition

Menstrual problems (women only)
Psychiatric/psychological and emotional difficulties
Behavioral disorders (e.g., ADD, ADHD, Asperger syndrome, autism)
Bleeding disorders
Fainting spells
Thyroid disease
Kidney disease
Sickle cell disease
Seizures Last seizure: _____
Sleep disorders (e.g., sleep apnea) Use CPAP: Yes No
Abdominal/digestive problems
Surgery
Serious injury
Other

MEDICATIONS

List all medications currently used. (If additional space is needed, please photocopy this part of the health form.)
Inhalers and EpiPen information must be included, even if they are for occasional or emergency use only.

Medication _____
Strength _____ Frequency _____
Approximate date started _____
Reason for medication _____

Medication _____
Strength _____ Frequency _____
Approximate date started _____
Reason for medication _____

Medication _____
Strength _____ Frequency _____
Approximate date started _____
Reason for medication _____

Medication _____
Strength _____ Frequency _____
Approximate date started _____
Reason for medication _____

Medication _____
Strength _____ Frequency _____
Approximate date started _____
Reason for medication _____

Medication _____
Strength _____ Frequency _____
Approximate date started _____
Reason for medication _____

Administration of the above medications is approved by (if required by your state):

Parent/guardian signature and/or MD/DO, NP, or PA signature

Be sure to bring medications in sufficient quantities and the original containers. Make sure that they are NOT expired, including inhalers and EpiPens. You SHOULD NOT STOP taking any maintenance medication. (For more information about immunizations, as well as the immunization exemption form, see Scouting Safely on www.Scouting.org .)

High-adventure base participants:

Expedition/crew No.: _____ or staff position: _____

Part B

Informed Consent and Hold Harmless/Release Agreement

I understand that participation in Scouting activities involves a certain degree of risk and can be physically, mentally, and emotionally demanding. I also understand that participation in these activities is entirely voluntary and requires participants to abide by applicable rules and standards of conduct.

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 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. I have carefully considered the risk involved and give consent for myself and/or my child to participate in these activities. I approve the sharing of the information on this form with BSA volunteers and professionals who need to know of medical situations that might require special consideration for the safe conducting of Scouting activities. I 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 claims or liability arising out of this participation.

___ Without restrictions.

___ With special considerations or restrictions (list) :

TALENT RELEASE AGREEMENT

I hereby assign and grant to the local council and the Boy Scouts of America 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 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 the Boy Scouts of America, 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.

If I am participating at Philmont, Philmont Training Center, Northern Tier, or Florida Sea Base: I have also read and understand the risk advisories explained in Part D, *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.

Participant's name _____

Participant's signature _____ Date _____

Parent/guardian's signature _____ Date _____ (if participant is under the age of 18)

This Annual Health and Medical Record is valid for 12 calendar months.

ADULTS AUTHORIZED TO TAKE YOUTH TO AND FROM EVENTS:

You must designate at least one adult. Please include a telephone number.

1. Name _____ Telephone _____
2. Name _____ Telephone _____
3. Name _____ Telephone _____

Adults NOT authorized to take youth to and from events:

1. Name _____
2. Name _____
3. Name _____

Part B Full name: _____ **DOB:** _____