

# Pre-Event Medical Screening Checklist

Person Completing Form \_\_\_\_\_ Date \_\_\_\_\_

Name of Participant \_\_\_\_\_ Age Group \_\_\_\_\_

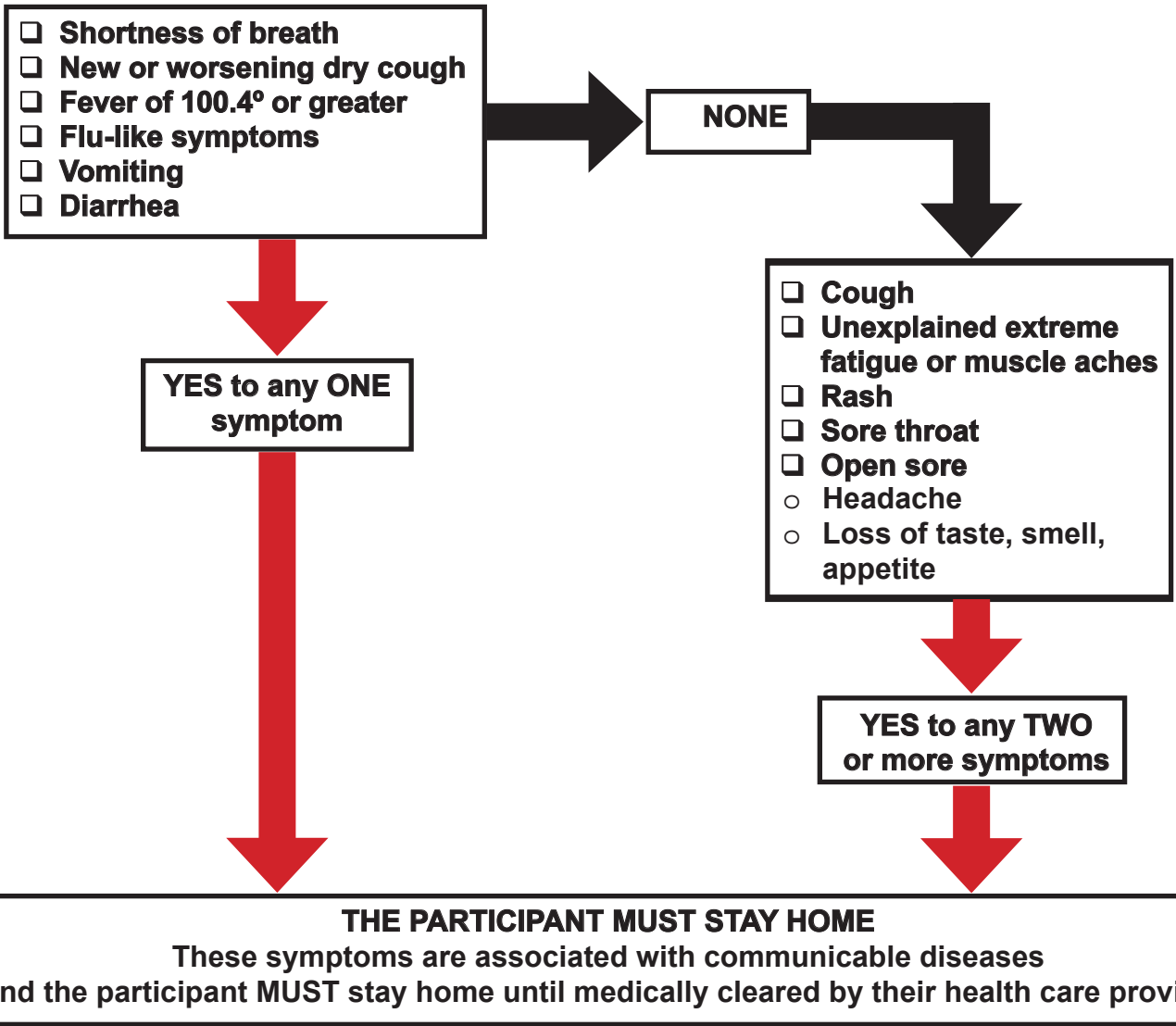
- This checklist assists in identifying potentially communicable diseases before event participation.
- Complete this checklist **for each participant before leaving home** for the event.
- It will be reviewed and turned in upon arrival at the event.
- This checklist is to be completed by anyone entering a camp or event (visitors, staff, vendors, etc.)

***If the answer is “yes” to question 1 or 2, the participant must stay home.***

- Yes  No 1. Have you been in contact with anyone who has COVID-19 or is otherwise sick?
- Yes  No 2. Have you or anyone you have been in close contact with traveled on a cruise ship, internationally, or to an area with a known communicable disease outbreak in the last 14 days?
- Yes  No 3. Are you in a higher-risk category as defined by the CDC guidelines?\*

\*If the answer is “yes” to question 3, we recommend that you stay home. Should you choose to participate, you must show written approval from your healthcare provider and proceed to the symptom decision tree below.

***If the above answers are “no,” answer the questions below that cover the 14 days prior to arriving at camp.***



COVID-19 Risk Acknowledgement

EACH CAMP ATTENDEE MUST COMPLETE THIS FORM AND TURN IN AT CAMP

Print Name \_\_\_\_\_ Unit Type & Number \_\_\_\_\_

The safety of all Scouts, volunteers and staff is the Capitol Area Council’s top priority.

Our council leaders continue to review national, state, and local health department recommendations to ensure we comply with their guidance to mitigate the risks of COVID-19 being contracted at our camps and facilities.

Our mitigation plan includes:

- Pre-attendance education.
- Health screening conducted by your unit prior to travel to our camp, including a temperature check.
  - o Note: See Pre-event Medical Screening flow chart.
- Health screening upon arrival at camp on all persons that enter camp. This screening will be conducted by our camp health officers, which will also include a temperature check. If anyone in the unit does not pass the arrival screening, the entire unit will not be allowed to enter camp.
- Limiting visitors in camp. (Parents should drop Scouts at camp parking lot and not enter camp)
- PPE Requirements: Masks must be worn in buildings and when 6-foot distancing cannot be observed.
- Extra handwashing/sanitizer stations throughout camp.
- Enhanced cleaning and disinfection of high-touch surfaces and shared program equipment.
- Food Service Protocols to stop potential spread of bacteria and virus.
- An emergency response plan that includes an isolation and quarantine protocol should a person at camp develop symptoms of COVID-19 or other communicable disease.

Experts have said that people with COVID-19 may show no signs or symptoms of illness, but can still spread the virus, and people may be contagious before their symptoms occur. The fact is that someone with COVID-19 may pass the required health screenings and be allowed into camp. We also know the very nature of camp makes social distancing difficult in many situations and impossible in others.

Information from the Centers for Disease Control and Prevention (CDC) states that older adults and people of any age who have serious underlying medical conditions are at higher risk for severe illness from COVID-19. If you are in this group, please ensure you have approval from your health care provider prior to attending camp.

Every staff member, volunteer, and Scouting family must evaluate their unique circumstances and make an informed decision before attending camp. We hope this information will be helpful as you make that choice.

I understand that there is risk due to the contagious nature of COVID-19 and that the protocols outlined above constitute reasonable barriers to mitigate that risk.

\_\_\_\_\_  
Signature of Parent / Guardian / Adult

\_\_\_\_\_  
Date

## **Parental Commitment to Transport**

### **To be completed and submitted to camp upon arrival**

I understand that any time during my child's stay at any Capitol Area Council Camp Property I may be called on to transport my camper (youth or adult) from camp for medical reasons. I commit to being available for the duration of the session by phone should I need to be contacted by the camp management team. Furthermore, upon consultation with the camp management team I agree to pick up my participant within 8 hours of being contacted. I will also provide a second level contact to be prepared for unforeseen circumstances.

\_\_\_\_\_  
Participant Name

\_\_\_\_\_  
Unit Type & Number

\_\_\_\_\_  
Signed

\_\_\_\_\_  
Date

\_\_\_\_\_  
Primary Contact Name

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Secondary Contact Name

\_\_\_\_\_  
Phone

## Part A: Informed Consent, Release Agreement, and Authorization

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: \_\_\_\_\_



## Part B1: General Information/Health History

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 <input type="checkbox"/> No <input type="checkbox"/>
		Hypertension (high blood pressure)	
		Adult or congenital heart disease/heart attack/chest pain (anginal)/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 <input type="checkbox"/> No <input type="checkbox"/>
		List all surgeries and hospitalizations	Last surgery date: _____
		List any other medical conditions not covered above	



## Part B2: General Information/Health History

Full name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

**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				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 <b>(form required)</b>	

**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: \_\_\_\_\_

