FRONTIER DISTRICT

SPRING 2013
CAMPOREE
AND SERVICE PROJECT

AT

Camp Tahosa

May 3rd through May 5th

Directions to Boy Scouts of America
173 County Road 96, Ward, CO 80481 - (303) 440-4040
52.5 mi – about **1 hour 23 mins**

Frederic C. Hamilton Scout Headquarters, Boy Scouts of America
10455 W 6th Ave, Lakewood, CO 80215 - (303) 455-5522

Step	Directions	Distance
1.	Head **east** on **W 6th Ave** toward **Miller Ct** About 51 secs	go 0.4 mi total 0.4 mi
2.	Turn right onto **Kipling St**	go 92 ft total 0.4 mi
3.	Slight right onto the **U.S. 6 W/6th Avenue** ramp	go 0.2 mi total 0.6 mi
4.	Merge onto **US-6 W** About 4 mins	go 3.8 mi total 4.4 mi
5.	Slight left onto **US-6 W/6th Ave** About 7 mins	go 3.7 mi total 8.2 mi
6.	Continue onto **CO-93 N** About 11 mins	go 8.3 mi total 16.4 mi
7.	Turn left onto **CO-72 W/Coal Creek Canyon Rd** About 22 mins	go 13.0 mi total 29.4 mi
8.	Turn right to stay on **CO-72 W/Coal Creek Canyon Rd** About 9 mins	go 5.7 mi total 35.1 mi
9.	Turn right onto **CO-119/CO-72 W/Peak to Peak Hwy** Continue to follow CO-72 W About 5 mins	go 3.0 mi total 38.0 mi
10.	At the traffic circle, take the **4th** exit onto **W 2nd St** About 1 min	go 0.3 mi total 38.3 mi
11.	Continue onto **CO-72 W/Caribou St** Continue to follow CO-72 W About 20 mins	go 14.0 mi total 52.4 mi
12.	Turn left onto **Co Rd 96/Beaver Reservoir Rd** Destination will be on the left About 1 min	go 0.2 mi total 52.5 mi

Boy Scouts of America
173 County Road 96, Ward, CO 80481 - (303) 440-4040

These directions are for planning purposes only. You may find that construction projects, traffic, weather, or other events may cause conditions to differ from the map results, and you should plan your route accordingly. You must obey all signs or notices regarding your route.

Map data ©2013 Google

Directions weren't right? Please find your route on maps.google.com and click "Report a problem" at the bottom left.

INFORMATION AND GUIDELINES

A. Guidelines:

The rules and guiding principles for the 2013 Camporee shall be the Scout Oath and Scout Law. Safety guidelines shall meet or exceed those outlined in the BSA Guide to Safe Scouting.

B. Registration:

Please see registration form

C. Second Year Webelo Participation:

All second year Webelo MUST be guests of a Scout Troop. Webelos leaders needing help finding a Troop should call Zenia, the Frontier District Administrative Assistant at 720.266.2114. The 2013 Camporee is an excellent opportunity for Webelos to observe Scout Troops in action, have fun, and learn more about Scouting. Please list your hosting unit on Medical Forms. Each Webelo must have a parent attend as a chaperone.

D. Check-in Procedures:

Check-In on Friday will be from 7:00 PM to 8:30 PM, and Saturday from 7:30 AM to 9:00 AM (for Webelos and day visitors). For Saturday arrivals, please check the Camporee Program Schedule and, if possible, arrive before the program day starts. Units expecting to arrive before 5:00 p.m. on Friday should communicate with J.D. Leonard (303-379-9150) or Ryan Thompson at the BSA office (303-455-5522). At check-in, each unit should be prepared to present the following:

- A Final Unit Roster.
- Signed Medical Release Form for each person listed on the roster. This form is included with this packet. No medical release forms will be returned. Every participant (youth or adult) must have a medical release form on file in order to participate in the event.
- Registration information and Fees Recorded. The registrar will have information on pre registrations and fees paid through the Scout Office. If you are late to register, bring your receipt, or a check (or cash) to cover fees.

E. Camp Sites

Each unit must have its camp site inspected by staff prior to departure. Upon successful inspection, the unit leader should go to the HQ Check-Out Area to pick up their patrol patches, etc. Please pick up this envelope before leaving. Follow the Outdoor Code in preparing your site for check-out. All units need to be checked out by 11:00AM on Sunday.

Saturday Check-Out: Troops needing to check out Saturday should specify their check-out time on their Troop Roster. Please note check out times on the Camporee schedule.
When ready to check-out, request a staff member at HQ to inspect your campsite. Units should have their campsites inspected before it gets dark. Upon satisfactory inspection, the unit leader should go to the HQ Check-Out Area to pick up their program envelope.

F. Food and Water

Each individual Troop is responsible for their meals, snack and water during Camporee. . Each unit is responsible for bringing their own water. There is limited water available at the site. Please plan accordingly. Since open fires are not allowed at this time, please remember camp stoves.

G. Parking Vehicles and Unloading Equipment:

Parking will be permitted in designated areas only. Please follow all signs, directions and prompts made by staff while driving and parking your vehicle. Vehicles may be able to transport gear to the campsite, but must return to the parking area as soon as they are unloaded.
PLEASE BE PATIENT and remember, **absolutely no vehicles are allowed in the campsite**.

H. First Aid:

Each Unit should have a good first aid kit in their campsite and should handle all minor first aid occurrences. Please see the staff for any first aid emergencies.

I. Campsites:

Campsites will be assigned based on when units register and troop size indicated at registration. A campsite map will be given to you at time of Check-In. Please remember that no tents, tarps, etc. may be tied to trees or structures.

J. Cooking & Fires:

No open fires will be allowed at this time. Any changes to the Fire Restrictions will be announced when checking in.

L. Trash:

This is a low impact event. Everything brought in must be packed out, including trash, ashes, etc. There is no dumpster!

M. Latrines:

Latrines will be provided near campsites. Please remind your scouts to be courteous, keep latrines clean, and observe posted restrictions for "Women Only and "Staff only."

N. Drink Stations:

Bring ample water as drink stations may not be available during Saturday's program. Each participant should add a cup to their 10 essentials

O. Quiet Time:

All lights and fires are to be extinguished by 10:00 PM. As a courtesy to others, please observe QUIET TIME from 10 PM to 6 AM.

P. Miscellaneous:

No pets are allowed during this event.
No weapons, ammunition, or fireworks of any sort are allowed.
Alcoholic beverages and illegal drugs are not permitted.
No smoking in event or campsite areas. Adults are asked not to smoke in the presence of Scouts.

2010 Frontier District Camporee Schedule
Tentative Program Schedule

Friday, May 3rd 2013

7:00 pm – 8:30 pm	Check-in
9:00 pm	Campfire
10:00 pm	Quiet Time

Saturday, May 4th 2013

6:30 am	Breakfast at your unit cooking area
8:00 am	Opening Ceremonies
8:30 am	Morning Activities
11:30 am	Lunch at your unit cooking area
12:30 pm	Afternoon Activities
6:30 pm	Dinner at your unit cooking area
8:30 pm	Campfire
10:00 pm	Quiet Time

Sunday, May 5th 2013

7:00 am	Breakfast at your unit cooking area
8:00 am	Opening Ceremonies
8:30 am	Church service by unit
	Camp tear down
12:00 pm	All units ready to depart

Suggested Equipment List

Check with your Scoutmaster and Boy Scout Handbook for additional Information

Personal Equipment

_____ Sleeping Bag
_____ Ground Cloth
_____ Sleeping Pad
_____ Cup, Bowl and Utensils
_____ Sunscreen & Lip Balm
_____ Sunglasses
_____ Toilet Paper (in zip-lock bag)

Clothing

_____ Class A Uniform
_____ Underwear
_____ Socks
_____ Pants
_____ Long Sleeved Shirt
_____Warm Jacket
_____ Hiking Boots

Group Equipment

_____ Flags
_____ Tents, Poles, Stakes
_____ Cooking Gear
_____ Stove & Fuel
_____ Food
_____ Water (LOTS)
_____ Dishpans & Soap
_____ Trash Bags
_____ Toilet Paper
_____ First Aid Kit

Ten Plus Essentials

_____ Pocket Knife
_____ First Aid Kit
_____ Extra Clothing
_____ Water Bottle (with water)
_____ Flashlight w/ Extra Batteries
_____ Trail Food
_____ Sunscreen & Lip Balm
_____ Cup (for drinks)
_____ Small Day Pack
_____ Rain Gear
_____ Notebook & Pencil
_____ Matches & Fire Starters
_____ Scout Handbook
_____ Compass
_____ Work Gloves

As our service project, we will be raking pine needles, stock-piling brush, painting tables and poles and tree planting. Work gloves and boots are highly recommended.

WEATHER

As everyone knows, the weather can change radically from one day to the next.

May Camporee weather can vary from sunny and warm to cold and snowy, sometimes at the same Camporee.

Please pay attention to weather forecasts and come prepared for all possibilities.

2013 FALL CAMPOREE — UNIT ROSTER

(To be turned in when arriving at Fall Camporee Check-In)

TROOP/TEAM/CREW # (Circle One) ____________ NUMBER OF PATROLS ______

DEPARTURE DAY: SATURDAY ___ SUNDAY ___

TROOP/TEAM/CREW # (Circle One) ____________ NUMBER OF PATROLS ______

DEPARTURE DAY: SATURDAY ___ SUNDAY ___ NUMBER OF DRINKS ______

NUMBER OF PARTICIPANTS:

Youth - 2 nights _________ Youth - 1 night _________ Youth - day only _________

Adults - 2 nights _________ Adults - 1 night _________ Adults - day only _________

TOTAL PARTICIPANTS _________

NOTES:

1) Please circle the names of one adult per patrol who will serve as volunteers to help run events.
2) Each patrol is responsible for providing one container of Drink Mix. These will be used at drink stations during Saturday's program.

PLEASE LIST THE NAMES OF ALL PARTICIPATING YOUTH AND ADULTS

SCOUTS	ADULTS	POSITION
1. Senior Patrol	1.	Scoutmaste
2.	2.	
3.	3.	
4.	4.	
5.	5.	
6.	6.	
7.	7.	
8.	8.	
9.	9.	
10.	10.	
11.	11.	
12.	12.	
13.	13.	

Annual Health and Medical Record
Registro Médico y de Salud Anual

(Valid for 12 calendar months)
(Válido por 12 meses calendario)

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 release agreement, and talent release statement is to be completed by the participant and parents/guardians. Attach a copy of both sides of your insurance card.

Part C is the pre-participation 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 heath-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. See the FAQs for when this does not apply.

Part D is required to be reviewed by all participants of a high-adventure program at one of the national high-adventure bases, as well as unit-based, high-adventure backcountry activities, 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.
- **Summit Bechtel Reserve.**

Política para el uso del Registro Médico y de Salud Anual

A fin de proporcionar una mejor atención para sus miembros y para ayudarles a entender mejor sus propias capacidades físicas, Boy Scouts of America recomienda que todos aquellos que participen en un evento Scouting se sometan a un examen médico anual realizado por un prestador de servicios de salud certificado y con licencia: un médico (Doctor en medicina o Doctor en osteopatía), enfermera profesional o asistente médico. Proporcionar su información médica en este formulario de cuatro partes, ayudará a asegurar que usted cumple con los estándares mínimos de participación en varias actividades. Tome en cuenta que los líderes de unidad siempre deben proteger la privacidad de los participantes al salvaguardar su información médica.

Las Partes A y B las deben completar, por lo menos una vez al año, los participantes de todos los eventos Scouting. Este historial médico, notificación de consentimiento y convenio de exoneración de responsabilidad por parte de los padres/tutores, y formulario de cesión de derechos lo deben completar los participantes y los padres/tutores. Anexar una copia de ambos lados de su tarjeta del seguro.

La Parte C es el examen físico previo, que se requiere de los participantes de cualquier evento que exceda 72 horas consecutivas, para todos los participantes de las bases de aventura extrema, o cuando la naturaleza de la actividad es extenuante y exigente. Los proyectos de servicio o fines de semana de trabajo pueden caer en esta descripción. La Parte C la debe completar y firmar un prestador de servicios de salud certificado y con licencia: un médico (Doctor en medicina o Doctor en osteopatía), enfermera profesional o asistente médico. Es importante tomar en cuenta que los límites de estatura y peso deben ser estrictamente controlados cuando el evento llevará a la unidad a más de 30 minutos de un vehículo de emergencia, camino accesible, o cuando el programa lo requiera, tal como expediciones, actividades de aventura extrema y proyectos de conservación en áreas remotas. Consulte las Preguntas Frecuentes para cuando estos lineamientos no aplican.

La Parte D se requiere que la revisen todos los participantes del programa de aventura extrema en una de las bases nacionales de aventura extrema, así como actividades de aventura extrema en zonas aisladas basadas en la unidad, y que la compartan con el prestador de servicios de salud antes de completar la Parte C.

- **Rancho Scout Philmont.** Los participantes e invitados en las actividades Philmont que se realicen con acceso limitado a las zonas campestres, incluyendo la mayoría de las conferencias y programas familiares en el Centro de Capacitación Philmont, no requerirán llenar la Parte C. Sin embargo, los participantes deberán repasar la Parte D para entender los riesgos potenciales inherentes a los 6,700 pies de elevación en un ambiente seco del Suroeste. Favor de revisar la información de registro específica para la actividad o evento.
- **Base nacional de aventura extrema Northern Tier.**
- **Base nacional marina de aventura extrema de la Florida.** También se requiere el formulario médico PADI si se va a bucear en esta base.
- **Summit Bechtel Reserve.**

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.

- 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

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 the 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 Program: 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
- Summit Bechtel Reserve: www.summitblog.org or 304-250-6750

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

Factores de riesgo

Con base en la gran experiencia de la comunidad médica, BSA ha identificado los siguientes factores de riesgo que podrían limitar su participación en varias aventuras al aire libre.

- Peso corporal excesivo
- Enfermedad cardiaca
- Hipertensión (Presión arterial alta)
- Diabetes
- Convulsiones
- Falta de vacunación adecuada
- Asma
- Alergias/anafilaxia
- Lesiones musculares/óseas
- Trastornos psiquiátricos/psicológicos y emocionales

Para obtener más información sobre los factores de riesgo médicos, visite Scouting Safely en www.scouting.org.

Prescripciones

Tomar los medicamentos prescritos es responsabilidad del individuo que requiere el medicamento o del padre de familia o tutor del individuo. Un líder, después de haber obtenido toda la información necesaria, puede aceptar la responsabilidad de asegurarse de que un niño tome el medicamento necesario a la hora apropiada, pero BSA no obliga ni necesariamente anima al líder a que lo haga. Asimismo, si las leyes estatales son más limitantes, deben ser cumplidas.

Preguntas frecuentes

- Rancho Scout Philmont: www.philmontscoutranch.org ó 575-376-2281
- Base nacional de aventura extrema Northern Tier: www.ntier.org ó 218-365-4811
- Base nacional marina de aventura extrema de la Florida: www.bsaseabase.org ó 305-664-5612
- Jamboree Scout Nacional: www.bsajamboree.org
- Summit Bechtel Reserve: www.summitblog.org ó 304-250-6750

Para consultar las preguntas frecuentes sobre este Registro Médico y de Salud Anual, consulte Scouting Safely en línea en http://www.scouting.org/scoutsource/HealthandSafety.aspx. La información sobre la Ley de responsabilidad y transferibilidad de seguros médicos (HIPAA, por sus siglas en inglés) se encuentra en www.hhs.gov/ocr/privacy/.

BOY SCOUTS OF AMERICA®

680-001
2012 Printing
Rev. 9/2012

Annual Health and Medical Record
Registro Médico y de Salud Anual
Part A/Parte A

High-adventure base participants:
Participantes en la base de aventura extrema:
Expedition/crew No.
Expedición/grupo no.: ______
or staff position
o puesto fijo: ______

Emergency contact No.: ______
Teléfono en caso de emergencia

Allergies: ______
Alergías

DOB: ______
Fecha de nacimiento

Full name: ______
Nombre completo

Part A
Parte A

GENERAL INFORMATION/INFORMACIÓN GENERAL

Name ______ Date of birth ______ Age ______ ○ Male ○ Female
Nombre / Fecha de nacimiento (MM/DD/Year) - (MM/DD/Año) / Edad / Masculino / Femenino

Address ______ Grade completed (youth only) ______
Domicilio / Grado escolar completado (sólo niños)

City ______ State ______ Zip ______ Phone No. ______
Ciudad / Estado / Código postal / No. telefónico

Unit leader ______ Council name/No. ______ Unit No. ______
Líder de la unidad / Nombre y no. del concilio / No. de unidad

Social Security No. (optional; may be required by medical facilities for treatment) ______ Religious preference ______
No. de Seguro Social (opcional; puede ser solicitado por las instalaciones médicas para brindar tratamiento) / Preferencia religiosa

Health/accident insurance company ______ Policy No. ______
Compañía de seguro médico/accidental / No. de póliza

ATTACH A PHOTOCOPY OF BOTH SIDES OF INSURANCE CARD. IF YOU DO NOT HAVE MEDICAL INSURANCE, ENTER "NONE" ABOVE.
ANEXAR UNA FOTOCOPIA DE AMBOS LADOS DE LA TARJETA DEL SEGURO. SI USTED NO TIENE SEGURO MÉDICO, ESCRIBA "NINGUNO."

In case of emergency, notify/En caso de emergencia, notificar a:

Name ______ Relationship ______
Nombre / Parentesco

Address ______
Domicilio

Home phone ______ Business phone ______ Mobile phone ______
Teléfono de casa / Teléfono de oficina / Teléfono móvil

Alternate contact name ______ Alternate's phone ______
Nombre de contacto alterno / Teléfono del contacto alterno

HEALTH HISTORY/HISTORIAL MÉDICO

Do you currently have, or have you ever been treated for any of the following?
¿Tiene actualmente, o ha tenido alguna vez los siguientes?

Please fill in the bubbles as indicated below:
Por favor rellene los círculos tal como se indica a continuación:
Incorrect: ✔ ⊗ ◒ Correct: ●
Incorrecto / Correcto

Yes/Sí	No/No	Condition/Padecimiento	Explain/Explique
○	○	**Asthma** Asma — **Last attack:** (MM/YY) Último ataque: (MM/AA) ☐☐/☐☐	
○	○	**Diabetes** Diabetes — **Last HbA1c:** (Percentage) Última HbA1c: (Porcentaje) ☐☐.☐ %	
○	○	**Hypertension (high blood pressure)** Hipertensión (presión alta)	
○	○	**Heart disease/heart attack/chest pain/heart murmur** Enfermedad del corazón/infarto/dolores de pecho/soplo cardíaco	
○	○	**Stroke/TIA** Apoplejía/Accidente isquémico transitorio	
○	○	**Lung/respiratory disease** Enfermedades pulmonares/respiratorias	
○	○	**Ear/sinus problems** Problemas del oído/senos paranasales	
○	○	**Muscular/skeletal condition** Condiciones musculares/óseas	
○	○	**Menstrual problems (women only)** Problemas menstruales (sólo mujeres)	
○	○	**Psychiatric/psychological and emotional difficulties** Dificultades psiquiátricas/psicológicas y emocionales	
○	○	**Behavioral/neurological disorders** Trastornos de conducta/neurológicos	
○	○	**Bleeding disorders** Enfermedades hemorrágicas	
○	○	**Fainting spells** Desmayos	
○	○	**Thyroid disease** Enfermedades de la tiroides	
○	○	**Kidney disease** Enfermedades del riñón	
○	○	**Sickle cell disease** Anemia falciforme	
○	○	**Seizures** Convulsiones — **Last seizure:** (MM/YY) Última convulsión: (MM/AA) ☐☐/☐☐	
○	○	**Sleep disorders (e.g., sleep apnea)** Trastornos del sueño (por ejemplo, síndrome de apnea-hipopnea durante el sueño)	Use CPAP: Usa CPAP ○ Yes Sí ○ No No
○	○	**Abdominal/digestive problems** Problemas abdominales/digestivos	
○	○	**Surgery** Cirugía — **Last surgery:** (MM/YY) Última cirugía: (MM/AA) ☐☐/☐☐	
○	○	**Serious injury** Lesión grave	
○	○	**Excessive fatigue or shortness of breath with exercise** Fatiga en exceso o dificultad para respirar al hacer ejercicio	
○	○	**Other** Otro	

PART A (*continued on next page*)

Part A Full name: ______ DOB: ______
Parte A Nombre completo ______ Fecha de nacimiento ______

HEALTH HISTORY/HISTORIAL MÉDICO

Are you allergic to or do you have any adverse reaction to any of the following?
¿Es alérgico a, o le causa alguna reacción adversa cualquiera de los siguientes?

Please fill in the bubbles as indicated: Incorrect: ✔ ✖ ◒ Correct: ●
Por favor rellene los círculos tal como se indica: Incorrecto Correcto

Yes/Sí	No/No	Allergies or Reaction to Alergias o Reacciones a	Explain Explique
○	○	**Medication** Medicamentos	
○	○	**Food, plants, or insect bites** Alimentos, plantas o picaduras de insectos	

The following immunizations are recommended by the BSA. **Tetanus immunization is required and must have been received within the last 10 years.** For each item, indicate if you have been immunized, the date of the immunization (MM/YY), if you have had the disease, and the date (MM/YY).

BSA recomienda las siguientes vacunas. **La vacuna contra el Tétanos es obligatoria y debe haberla recibido en los últimos 10 años.** Por cada punto, indique si ha sido vacunado, la fecha en que la recibió (MM/AA), si ha padecido la enfermedad, y la fecha (MM/AA).

Immunized? ¿Vacunado? Yes/Sí	Immunized? ¿Vacunado? No/No	Immunizations Vacunas	Date (MM/YY) Fecha (MM/AA)	Had Disease? ¿La ha padecido? Yes/Sí	Had Disease? ¿La ha padecido? No/No	Date (MM/YY) Fecha (MM/AA)
○	○	**Tetanus** Tétano	☐☐ / ☐☐	○	○	
○	○	**Pertussis** Tos ferina		○	○	
○	○	**Diphtheria** Difteria		○	○	
○	○	**Measles** Sarampión		○	○	
○	○	**Mumps** Paperas		○	○	
○	○	**Rubella** Rubéola		○	○	
○	○	**Polio** Polio		○	○	
○	○	**Chicken pox** Varicela		○	○	
○	○	**Hepatitis A** Hepatitis A		○	○	
○	○	**Hepatitis B** Hepatitis B		○	○	
○	○	**Meningitis** Meningitis		○	○	
○	○	**Influenza** Influenza		○	○	
○	○	**Other (i.e., HIB)** Otra (por ejemplo, HIB)		○	○	
○	**Exemption to immunizations claimed (form required).** Exención de vacunas solicitada (formulario obligatorio).					

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.

MEDICAMENTOS Enumere todos los medicamentos que usa en la actualidad. (Si requiere espacio adicional, favor de sacar una fotocopia de esta parte del formulario.) Se debe incluir información sobre inhaladores y EpiPen, incluso si son sólo para uso ocasional o en caso de emergencia.

○ No medications
Sin medicamentos

○ Additional medications (sheet attached)
Medicamentos adicionales (hoja anexa)

Medication Medicamento ______ Strength Dosis ______ Frequency Frecuencia ______ Approximate date started Fecha aproximada de inicio ______ Reason for medication Razón del medicamento ______	Medication Medicamento ______ Strength Dosis ______ Frequency Frecuencia ______ Approximate date started Fecha aproximada de inicio ______ Reason for medication Razón del medicamento ______	Medication Medicamento ______ Strength Dosis ______ Frequency Frecuencia ______ Approximate date started Fecha aproximada de inicio ______ Reason for medication Razón del medicamento ______
Medication Medicamento ______ Strength Dosis ______ Frequency Frecuencia ______ Approximate date started Fecha aproximada de inicio ______ Reason for medication Razón del medicamento ______	Medication Medicamento ______ Strength Dosis ______ Frequency Frecuencia ______ Approximate date started Fecha aproximada de inicio ______ Reason for medication Razón del medicamento ______	Medication Medicamento ______ Strength Dosis ______ Frequency Frecuencia ______ Approximate date started Fecha aproximada de inicio ______ Reason for medication Razón del medicamento ______

Administration of the above medications is approved by (if required by your state): ______ / ______
La administración de los medicamentos arriba mencionados está aprobada por (si lo requiere su estado)

Parent/guardian signature / Firma del padre o tutor — and/or / y/o — MD/DO, NP, or PA signature / Firma del Dr., Enfermera profesional, Asistente médico

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.

Asegurarse de traer los medicamentos en cantidades suficientes y en los envases originales. Asegurarse de que NO ESTÉN CADUCADOS, incluyendo inhaladores y EpiPens. NO DEBE DEJAR DE tomar cualquier medicamento de mantenimiento a menos que se lo indique su médico.

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High-adventure base participants:
Participantes en la base de aventura extrema:
Expedition/crew No./Expedición/grupo no.: ____________________________
or staff position/o puesto fijo: ____

Part B/Parte B

INFORMED CONSENT AND 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.

NOTIFICACIÓN DE CONSENTIMIENTO Y EXONERACIÓN DE RESPONSABILIDAD

Entiendo que la participación en actividades Scouting implica un cierto grado de riesgo y que pueden ser física, mental y emocionalmente agotadoras. Asimismo, entiendo que la participación en dichas actividades es completamente voluntaria y requiere que los participantes se acaten a las reglas y estándares de conducta pertinentes.

En caso de que yo, o mi hijo, nos veamos involucrados en un caso de emergencia, entiendo que se hará todo lo posible para contactar al individuo mencionado como persona a contactar en caso de emergencia. En caso de que dicha persona no pueda ser localizada, por este medio otorgo permiso al proveedor de servicios médicos seleccionado por el líder adulto a cargo para asegurar que se proporcione el tratamiento adecuado, incluyendo hospitalización, anestesia, cirugía o inyecciones de medicamentos para mí o mi hijo. Los proveedores médicos están autorizados a compartir información médica protegida con el adulto a cargo, el personal médico del campamento, la administración del campamento, o cualquier médico o proveedor de servicios médicos involucrado en la administración de atención médica al participante. La Información médica protegida/Información médica confidencial (PHI/CHI, por sus siglas en inglés) bajo los Estándares de privacidad de información médica individualmente identificable, 45 C.F.R. §§160.103, 164.501, etc., y siguientes como se enmiendan de vez en cuando, incluye resultados de reconocimientos médicos, resultados de pruebas y tratamiento proporcionado para propósitos de evaluación médica del participante, seguimiento y comunicación con los padres o tutor del participante, y determinación de la habilidad del participante de continuar con las actividades del programa.

He considerado cuidadosamente el riesgo implicado y he dado el consentimiento para mí mismo o mi hijo de participar en dichas actividades. Apruebo que se comparta la información contenida en este formulario con los voluntarios y profesionales de BSA que necesiten tener conocimiento de condiciones médicas que puedan requerir consideración especial para la realización de actividades Scouting de manera segura.

Eximo a Boy Scouts of America, al concilio local, a los coordinadores de la actividad y a todos los empleados, voluntarios, grupos involucrados u otras organizaciones asociadas con la actividad, de cualquier y toda reclamación o responsabilidad que surja a raíz de esta participación.

◯ Without restrictions./Sin restricciones.

◯ With special considerations or restrictions (list)/Con condiciones especiales o restricciones (lista):

____

____

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.

Por este conducto asigno y otorgo al concilio local y a Boy Scouts of America el derecho y permiso para usar y publicar las fotografías/películas/videocintas/representaciones electrónicas y grabaciones de sonido de mí o mi hijo realizadas en todas las actividades Scouting, y por este medio exonero a Boy Scouts of America, al concilio local, a los coordinadores de la actividad y a todos los empleados, voluntarios, grupos involucrados u otras organizaciones asociadas con la actividad, de cualquier y toda responsabilidad por dicho uso y publicación.

Por este conducto autorizo la reproducción, venta, derechos reservados, exhibición, transmisión, almacenamiento electrónico y distribución de dichas fotografías/películas/ videocintas/representaciones electrónicas y grabaciones de sonido sin limitación a discreción de Boy Scouts of America, y específicamente renuncio a cualquier derecho de compensación alguna que pueda tener por cualquiera de lo anterior.

◯ Yes/Sí

◯ No/No

Part B / Parte B
Full name: / Nombre completo: ____________
DOB: / Fecha de nacimiento: ____________

PART B (*continued on next page*)

ADULTS AUTHORIZED TO TAKE YOUTH TO AND FROM EVENTS:

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

ADULTOS AUTORIZADOS PARA TRANSPORTAR AL NIÑO HACIA Y DESDE LOS EVENTOS:

Debe designar por lo menos a un adulto. Por favor incluya un número telefónico.

1. Name/Nombre ____________________ Telephone/Teléfono ____________
2. Name/Nombre ____________________ Telephone/Teléfono ____________
3. Name/Nombre ____________________ Telephone/Teléfono ____________

Adults NOT authorized to take youth to and from events/Adultos NO autorizados para transportar al niño hacia y desde los eventos:

1. Name/Nombre ____________________ Telephone/Teléfono ____________
2. Name/Nombre ____________________ Telephone/Teléfono ____________
3. Name/Nombre ____________________ Telephone/Teléfono ____________

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, Florida Sea Base, or the Summit Bechtel Reserve: 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. If the participant is under the age of 18, a parent or guardian's signature is required.

Entiendo que, si cualquier información que he/hemos proporcionado es errónea, puede limitar o eliminar la oportunidad de participación en cualquier evento o actividad.

Si participo en Philmont, el Centro de Capacitación Philmont, Northern Tier, la Base Marina de la Florida o Summit Bechtel Reserve: También he leído y entiendo las advertencias de riesgo explicadas en la Parte D, *incluyendo los requisitos y restricciones de estatura y peso*, y entiendo que al participante no se le permitirá intervenir en programas de aventura extrema si dichos requisitos no se cumplen. El participante tiene permiso de intervenir en todas las actividades de aventura extrema descritas, excepto aquellas específicamente señaladas por mí o el proveedor de servicios médicos. Si el participante es menor de 18 años, se requiere la firma de el padre/madre o tutor.

Participant's name/Nombre del participante ____________________

Participant's signature/Firma del participante ____________ Date/Fecha ______

Parent/guardian's signature/Firma del padre o tutor ____________ Date/Fecha ______

(if participant is under the age of 18/si el participante es menor de 18 años)

Second parent/guardian signature/Firma del otro padre o tutor ____________ Date/Fecha ______

(if required; for example, CA/si se requiere; por ejemplo en CA)

This Annual Health and Medical Record is valid for 12 calendar months.
Este Registro Médico y de Salud Anual tiene vigencia por 12 meses calendario.

680-001
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COLORADO LAW REQUIRES THAT THIS FORM BE COMPLETED FOR EACH SCOUT ATTENDING A COLORADO SCOUT CAMP

Name______________________________ **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______	

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 ________________
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 motives 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 #______________________________

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__________ 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________________