Part A: Informed Consent, Release Agreement, and Authorization

A

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

B1

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** ☐ **No** ☐
☐	☐	Hypertension (high blood pressure)	
☐	☐	Adult or congenital heart disease/heart attack/chest pain (angina)/ 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** ☐ **No** ☐
☐	☐	List all surgeries and hospitalizations	**Last surgery date:**
☐	☐	List any other medical conditions not covered above	

Part B2: General Information/Health History

B2

Full name: _____

Date of birth: _____

High-adventure base participants:
Expedition/crew No.: _____
or staff position: _____

Allergies/Medications

DO YOU USE AN EPINEPHRINE AUTOINJECTOR? ☐ YES ☐ NO Exp. date (if yes) _____

DO YOU USE AN ASTHMA RESCUE INHALER? ☐ YES ☐ NO Exp. date (if yes) _____

Are you allergic to or do you have any adverse reaction to any of the following?

Yes	No	Allergies or Reactions	Explain
☐	☐	Medication	
☐	☐	Food	

Yes	No	Allergies or Reactions	Explain
☐	☐	Plants	
☐	☐	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

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 *Required for all adults and children**	
☐	☐		**Pertussis *Youth required**	
☐	☐		**Diphtheria *Youth required**	
☐	☐		**Measles/mumps/rubella *Youth required**	
☐	☐		**Polio *Youth required**	
☐	☐		**Varicella (Chicken Pox) *Youth required**	
☐	☐		Hepatitis A	
☐	☐		**Hepatitis B *Youth required**	
☐	☐		**Meningitis (MenACWY) *Youth required**	
☐	☐		Influenza	
☐	☐		Other (i.e., HIB)	
☐	☐		**Medical Exemption to immunizations (Health Care Provider Document Req.)**	

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: _____

Prepared. For Life.®

***Per Local Board of Health Public Health Order No. 1 - 2024 Children's Camps, all Summer Camps in Sullivan County including Ten Mile River Scout Camps is required to verify all campers have evidence of required vaccines or a valid medical exemption. Ten Mile River is not permitted any camper to attend camp unless such camper has provided evidence of all required immunizations. Please see pages 6-7 for more information.**

Part C: Pre-Participation Physical

C

This part must be completed by certified and licensed physicians (MD, DO), nurse practitioners, or physician assistants.

Full name: _____

Date of birth: _____

High-adventure base participants:

Expedition/crew No.: _____

or staff position: _____

You are being asked to certify that this individual has no contraindication for participation in a Scouting experience. For individuals who will be attending a high-adventure program, including one of the national high-adventure bases, please refer to the supplemental information on the following pages or the form provided by your patient. You can also visit www.scouting.org/health-and-safety/ahmr to view this information online.

Please fill in the following information:

	Yes	No	Explain
Medical restrictions to participate	☐	☐	

Yes	No	Allergies or Reactions	Explain
☐	☐	Medication	
☐	☐	Food	

Yes	No	Allergies or Reactions	Explain
☐	☐	Plants	
☐	☐	Insect bites/stings	

Height (inches)	Weight (lbs.)	BMI	Blood Pressure	Pulse
			/	

	Normal	Abnormal	Explain Abnormalities
Eyes	☐	☐	
Ears/nose/throat	☐	☐	
Lungs	☐	☐	
Heart	☐	☐	
Abdomen	☐	☐	
Genitalia/hernia	☐	☐	
Musculoskeletal	☐	☐	
Neurological	☐	☐	
Skin issues	☐	☐	
Other	☐	☐	

Examiner's Certification

I certify that I have reviewed the health history and examined this person and find no contraindications for participation in a Scouting experience. This participant (with noted restrictions):

True	False	Explain
☐	☐	Meets height/weight requirements.
☐	☐	Has no uncontrolled heart disease, lung disease, or hypertension.
☐	☐	Has not had an orthopedic injury, musculoskeletal problems, or orthopedic surgery in the last six months or possesses a letter of clearance from his or her orthopedic surgeon or treating physician.
☐	☐	Has no uncontrolled psychiatric disorders.
☐	☐	Has had no seizures in the last year.
☐	☐	Does not have poorly controlled diabetes.
☐	☐	If planning to scuba dive, does not have diabetes, asthma, or seizures.

Examiner's signature: _____ **Date:** _____

Examiner's printed name: _____

Address: _____

City: _____ State: _____ ZIP code: _____

Office phone: _____

Height/Weight Restrictions

If you exceed the maximum weight for height as explained in the following chart and your planned high-adventure activity will take you more than 30 minutes away from an emergency vehicle/accessible roadway, you may not be allowed to participate.

Maximum weight for height:

Height (inches)	Max. Weight	Height (inches)	Max. Weight	Height (inches)	Max. Weight	Height (inches)	Max. Weight
60	166	65	195	70	226	75	260
61	172	66	201	71	233	76	267
62	178	67	207	72	239	77	274
63	183	68	214	73	246	78	281
64	189	69	220	74	252	79 and over	295

Karen Holden BSN, RN, LNC
Director, Public Health
Acting Director of Patient Services

Jill Hubert-Simon, MS
Deputy Director

Sullivan County Department of Public Health
Gladys Olmsted Building
PO Box 590, 50 Community Lane
Liberty, NY 12754
Phone: (845) 292-5910
Fax #: (845) 513-2276

Local Board of Health Public Health Order No. 1 - 2024 Children's Camps

Implementing guidance based on 2023-24 School year New Yok State Immunization Requirements for School Entrance/Attendance

1. This Order shall apply to all camps operated within Sullivan County, in accordance with the New York State Public Health Law and Sanitary Code, 10 NYCRR 7-2.2, including summer day camps and children's overnight camps.

2. The camp health director shall verify all campers have evidence of required vaccines or a valid medical exemption. **This order excludes children that are five years old and younger.**

Upon arrival to camp, the camp operator, health director or designee shall screen children as part of the initial health screening pursuant to the camp's safety plan, for signs or symptoms of any potentially infectious disease, including vaccine preventable diseases/illness.

Additionally, the camp operator or health director shall request parents or guardians of campers to notify the camp operator or health director if such camper has had any possible exposures to the measles illness twenty-one days prior to attending camp and/or during the camp season.

All campers must have documentation of the following vaccinations administered prior to the beginning of camp:

- Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (Dtap/DTP/Tdap)
- Hepatitis B vaccine or proof of immunity
- Measles, Mumps and Rubella vaccine (MMR) or proof of immunity (positive titer)
- Polio vaccine (IPV/OPV)
- Varicella (Chickenpox) vaccine or proof of immunity
- Meningococcal conjugate vaccine (MenACWY)

3. No camp operator shall permit any camper to attend camp unless such camper has provided evidence of all required immunizations. In regards to measles specifically, a titer proving immunity will also suffice.

Evidence of immunity includes:

a) Written documentation from a health care provider of one or more doses of a measles containing vaccine (MMR);

b) Laboratory evidence of immunity;

c) Laboratory confirmation of measles; or

d) Birth before 1957

4. Notwithstanding, a camp operator may permit a camper who is in the process of receiving the required vaccine to attend camp. A camper who is "in the process of receiving the required vaccine" or "in-process" if the camper or has received at least the first dose of the required vaccine, has an appointment to complete a second dose of the required vaccine, based upon the current vaccination timelines. If a camper in attendance at a camp when the second dose of a required vaccine is scheduled, such camper or shall receive the second dose, or the camper shall be excluded from camp after the expiration of the vaccination dose interval, based upon the specific vaccine.

5. All camp operators shall maintain records of camper screening for signs or symptoms of illness or recent exposure to the above-mentioned vaccine preventable diseases. Any immune camper or who was exposed to a vaccine preventable disease within the twenty-one days prior to attending camp or during the camp season shall be monitored for signs and symptoms of disease while at camp, and the camp operator or health director shall immediately report any such known exposures to Sullivan County Department of Public Health and the New York Department of Health.

6. Failure to comply with this Commissioner's Order may result in legal action, including, but limited to, requiring your attendance at an administrative hearing, and may further result in the imposition of penalties in an amount not exceeding $2,000 for a single violation or failure to adhere to any of the provisions of this Order authorized by Public Health Law Section 309(1) (f).

7. The County Public Health Director is directed to undertake the actions necessary to enforce this Order.

8. This Order shall be effective upon its adoption.

Individualized Medication Orders
STANDARD OVER-THE-COUNTER/PRN MEDICATIONS

CAMPER NAME: _____ **UNIT:** _____ **CAMP:** _____

CAMPER WEIGHT: _____ **lbs**. **DATE OF BIRTH**:

HEALTHCARE PROVIDER NAME: _____ **LICENSE #**: _____

ADDRESS: _____

HEALTHCARE PROVIDER SIGNATURE: _____ **DATE**: ____/____/_____

I recognize that this is a two-page document

HEALTHCARE PROVIDER STAMP:

By order of the NYS Department of Health, this form is required for all campers under 18 years of age, and must be accompanied by a completed Annual BSA Health and Medical Record Form.

The following medications may be available in the camp Health Lodge and will be administered at the discretion of the camp Medical Officer, **if approval** is ordered by the Healthcare Provider below.

Do not send these medications to camp; they may be at the Health Lodge

DRUG NAME	ROUTE *circle preferred formulation*	DOSAGE	SCHEDULE	PROVIDER ORDER *check one*	COMMENTS
BENADRYL (25 to 50 mg)	PO (elixir, chewable tabs, pills)	Per label instructions by age/weight	Q 6 hr prn for allergic reaction (hives, insect bite)	☐ YES ☐ NO	
CEPACOL	PO (lozenges)	Per label instructions by age/weight	Q 2 hr for sore throat (no > 4 doses in 24 hr and no fever)	☐ YES ☐ NO	
CHILDREN'S DIMETAPP COLD & ALLERGY	PO (elixir, tabs)	Per label instructions by age/weight	Q 6-8 hr prn for nasal congestion/drainage	☐ YES ☐ NO	
IBUPROFEN (200 to 400 mg)	PO (chewable tabs, suspension, tabs)	Per label instructions by age/weight	Q 6 hr prn for pain or fever > _____ °F	☐ YES ☐ NO	
MYLANTA	PO (chewable tabs)	Per label instructions by age/weight	TID prn for stomach upset	☐ YES ☐ NO	
CHILDREN'S PEPTO BISMOL	PO (liquid, chewable tabs)	Per label instructions by age/weight	TID prn for stomach upset (no > 4 doses in 24 hr)	☐ YES ☐ NO	
ROBITUSSIN	PO (syrup)	Per label instructions by age/weight	Q 4 hr prn for cough	☐ YES ☐ NO	

Individualized Medication Orders
STANDARD OVER-THE-COUNTER/PRN MEDICATIONS

CAMPER NAME: _____**UNIT:** _____ **CAMP:** _____

DRUG NAME	ROUTE *circle preferred formulation*	DOSAGE	SCHEDULE	PROVIDER ORDER *check one*	COMMENTS
TYLENOL	PO (chewable tabs, elixir, tabs)	Per label instructions by age/weight	Q 4 hr prn for pain or fever > _____ °F	☐ YES ☐ NO	
CALADRYL	Topical	Per label instructions by age/weight	as directed for itches, bites, skin irritations, rashes	☐ YES ☐ NO	
BACITRACIN OINTMENT	Topical	Per label instructions by age/weight	as directed for minor cuts and abrasions	☐ YES ☐ NO	
TINACTIN (or equivalent)	Topical (liquid, powder)	Per label instructions by age/weight	as directed for athlete's foot, jock itch, fungal rash	☐ YES ☐ NO	

The medications above are the **only medications** that are available in the camp Health Lodge. If additional over-the-counter medications are required, the camper's parent/guardian must make arrangements to procure and send these medications to camp with the camper's unit leader. The Healthcare Provider should list any such medications below.

SELF-PROVIDED OVER-THE-COUNTER/PRN MEDICATIONS please ~~strike out this section~~ if not needed

				☐ YES ☐ NO	
				☐ YES ☐ NO	
				☐ YES ☐ NO	

GREATER NEW YORK COUNCILS BOY SCOUTS OF AMERICA

Dear Parent:

I am writing to inform you about meningococcal disease, a potentially fatal bacterial infection commonly referred to as meningitis, and a new law in New York State. On July 22, 2003, the New York State Public Health Law (NYS PHL) was amended to include §2167 requiring overnight children's camps to distribute information about meningococcal disease and vaccination to the parents or guardians of all campers who attend camp for 7 or more nights. This law became effective on August 15, 2003.

Ten Mile River Scout Camps are required to maintain a record of the following for each camper:

- A response to receipt of meningococcal meningitis disease and vaccine information signed by the camper's parent or guardian; AND
- Information on the availability and cost of meningococcal meningitis vaccine (Menomune™); AND EITHER
- A record of meningococcal meningitis immunization within the past 10 years; OR
- An acknowledgement of meningococcal (meningitis) disease risks AND AGE exemption from receiving the immunization; (according to CDC guidelines All 11 to 12 year-olds should receive a meningococcal conjugate vaccine. Children younger than this age do not.)

Meningitis is rare. However, when it strikes, its flu-like symptoms make diagnosis difficult. If not treated early, meningitis can lead to swelling of the fluid surrounding the brain and spinal column as well as severe and permanent disabilities, such as hearing loss, brain damage, seizures, limb amputation and even death.

Cases of meningitis among teens and young adults 15 to 24 years of age have more than doubled since 1991. The disease strikes about 3,000 Americans each year and claims about 300 lives.

A vaccine is available that protects against four types of the bacteria that cause meningitis in the United States types A, C, Y and W-135. These types account for nearly two thirds of meningitis cases among teens and young adults.

Information about the availability and cost of the vaccine can be obtained from your health care provider and by visiting the manufacturer's website at www.meningitisvaccine. com. Ten Mile River Scout Camps *do not offer MENINGOCOCCAL IMMUNIZATION SERVICES.*

For all Scouts attending camp for more than one week, **Please complete the Meningococcal Vaccination Response Form on the reverse side. This form should remain attached to your child's medical form and be brought to the camp.**

To learn more about meningitis and the vaccine, please feel free to contact Camping Services at 212- 651-2955, visit tenmileriver.org and/or consult your child's physician. You can also find information about the disease at the New York State Department of Health website: WWW.HEALTH.STATE.NY.US, and the website of the Center for Disease Control and Prevention (CDC): WWW.CDC.GOV/NCIDOD/DBMD/DISEASEINFO.

MENINGOCOCCAL MENINGITIS VACCINATION RESPONSE FORM

New York State Public Health Law requires the operator of an overnight children's camp to maintain a completed response form for every camper who attends camp for seven (7) or more nights.

Check one box and sign below.

☐ My child has had the meningococcal meningitis immunization (Menomune™) within the past 10 years. Date received: _____ (Note: The vaccine's protection lasts for approximately 3 to 5 years. Revaccination may be considered within 3-5 years.)

☐ I am an attending adult and my last immunization date was: _____

☐ My child is not of age to obtain immunization against meningococcal meningitis disease.

☐ My child is medically exempt from obtaining immunization against meningococcal meningitis disease.

Attending Physicians:_____

Affirmation of Exemption/Stamp :

I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine.

Signed: _____ Date:_____

(Parent / Guardian)

Camper's Name: _____ Date of Birth : _____

Mailing Address: _____

Parent/Guardian's E-mail address (optional): _____

SUNSCREEN AND BUG SPRAY
PERMISSION FORM
GREATER NEW YORK COUNCILS, BSA

Parent/Guardian Permission Form
Use of Sunscreen and Insect Repellent at Ten Mile River Camps

New York State Public Health Law requires written parental permission for a child to carry and use sunscreen and bug repellent at camp. The legislation further requires the camp to maintain record of the parental permission and allows camp staff to assist with the application of sunscreen when the child is unable to do so, provided the child requests the assistance and that this assistance is permitted/authorized by the parent.

Sunscreen Approval

☐ I give permission for _____ to carry and self-apply sunscreen. I understand that the following conditions must be met to promote proper and safe use of sunscreen and insect repellent at Camp:

1. The sunscreen will only be used to prevent overexposure to the sun.
2. Only sunscreen approved by the FDA for over-the-counter use will be permitted for use by the camper.
3. A child who is unable to physically apply sunscreen may be assisted by unlicensed personnel when directed to do so by the child, if permitted by a parent or guardian and authorized by the camp.

Bug Spray Approval

☐ I give permission for _____ to carry and self-apply insect repellant. I understand that the following conditions must be met to promote proper and safe use of insect repellent at Camp:

1. The insect repellent will only be used to prevent overexposure to insects.
2. Only insect repellent approved by the FDA for over-the-counter use will be permitted for use by the camper.
3. A child who is unable to physically apply insect repellent may be assisted by unlicensed personnel when directed to do so by the child, if permitted by a parent or guardian and authorized by the camp.

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____ Date : _____