



CAMP CLASS 2 MEDICAL EVALUATION

Heart of America Council, Boy Scouts of America

Unit Number

Scout's Name _____ Date of Birth _____ Unit # _____

NOTICE TO LICENSED PRACTITIONERS: The person being evaluated will be attending long term camp (5 to 9 days). Activities may include sleeping on the ground, participating in strenuous activities such as hiking, boating, and vigorous group games. Please review the health history on the reverse side, and discuss with the participant/parent. Please explain any abnormal findings.

Height _____ Weight _____ Blood Pressure _____/_____/_____ Pulse _____

Vision: OD _____ OS _____ OU _____

Participant wears glasses? Yes ___ No ___ Contacts? Yes ___ No ___

Hearing: Normal _____ Abnormal _____

Describe any hearing abnormality _____

If indicated: CBC/Hemoglobin _____

Urinalysis _____

District

| ITEM/SYSTEM | NL | ABNL | COMMENT |
|------------------------|----|------|---------|
| General appearance | | | |
| Growth and development | | | |
| Head | | | |
| Eyes | | | |
| Ears | | | |
| Nose | | | |
| Throat | | | |
| Cardiovascular | | | |
| Lungs | | | |
| Musculoskeletal | | | |
| Genital/Hernia | | | |
| Neurological | | | |
| Integument | | | |

General Assessment _____

Dietary Restrictions _____

Activity Restrictions _____

APPROVED FOR PARTICIPATION IN: Hiking and Camping Competitive Sports Water Activities All Activities No Activities

Licensed Practitioner* Signature _____

PA or RNP in Collaborative Practice with _____

Date of this Examination _____

Practitioner Address _____

City/State/Zip _____ Telephone Number _____

Name

*Licensed Practitioner means: Physician (MD or DO), Nurse Practitioner (RNP) or Physician's Assistant (PA). If signed by PA or RNP, the name of the MD/DO they are in collaborative practice with must be printed on this form in the space provided.