

BSA Health/Medical Record WFA Requirements COVID Mitigation @Philmont

NCAC HAC Training Session I
November 20, 2022
John Blackwell



BSA Health & Medical Record

- **Must use Current (2019) Edition for Philmont HA Base**
 - <https://www.philmontscoutranch.org/philmonttreks/healthform/>
- **4 Parts:**
 - A (Consent, 1 pg)
 - B (Health History, 2 pg)
 - C (Physical Exam, 1 pg)
 - Risk Advisory (2 pg, give to examiner)
- **Must be dated w/in 12 mo of trek, signed by examiner**



Part A: Informed Consent, Release Agreement, and Authorization

A

Full name: _____
Date of birth: _____

High school or home participation:
Registration No.: _____
or club number: _____

Informed Consent, Release Agreement, and Authorization

I understand that participation in Shooting activities involves the risk of personal injury, including death, due to the physical, mental, and emotional challenges in the activities offered. I understand that these activities may be obtained from the various, publicly accessible, or otherwise stated. I also understand that participants in these activities may be voluntarily and require 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 on the emergency contact person by the resident provider or other adult leader. In the event that it is deemed unsafe to proceed, permission is hereby given to the resident provider assisted by the adult leader to change in certain proper treatment, including transportation, medication, surgery, or if judged of necessity for me or my child. Medical permission are not related to shooting or related health interventions in the event of change, care; medical staff, emergency management, under any physician or health-care provider located in providing medical care to the participant. Federal Health Information Privacy Act (HIPAA), 45 C.F.R. §§164.502, 164.504, etc., etc., as amended then time to time, includes restrictions on release, use, and treatment provided for purposes of medical evaluation of the participant, if the age and consent of the child for purposes of the parent or guardian, and the determination of the participant's ability to consent to the program activities.

If applicable I have carefully considered the risks involved and hereby give my informed consent for my child to participate in all activities offered in the program. I further authorize the activity of the participant on this form with my BSA web address or permission who shall be later of a medical condition that may require special consideration in conducting the activity.

With appreciation of the dangers and risks associated with programs and activities, on my own behalf or on behalf of my child, I hereby fully and completely release and defend any and all claims for personal injury, death, or loss that may arise against the Boy Scouts of America, the local council, the activity coordinator, 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 and other non-commercial representations under usual recording means of me or my child at all Shooting activities, and I hereby release the Boy Scouts of America, the local council, the activity coordinator, 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 distribution of said photographs and other non-commercial representations under usual recording means facilities at the discretion of the BSA, and I specifically waive any right to my compensation I may have for any of the foregoing.

Every person who finishes any BSA activity in any way, without the express or implied permission of the parent or legal guardian of the minor, is guilty of a misdemeanor. (California Penal Code Section 26122) My signature below on this form indicates my permission.

I give permission for my child to use a BSA device. (Please list all events will include BSA devices)

Shooting this has indicated you are NOT using your child in non-BSA devices.

NOTE: Due to the nature of programs and activities, the Boy Scouts of America and local councils cannot automatically monitor occurrences of program participation or any behavior observed upon them by parents or medical providers. However, on that history may be an incident or possible with any activities, history may be based on a child participant's communication with program or activities below.

List participant activities, if any:

None

I understand that if any information has been provided to me to be accurate. If any that, either obtains the opportunity for participation in any event or activity. If I am participating at Philmont Scout Ranch, Philmont Training Center, Ironhorse Inn, Sun Peak, or the Ramon Scout Center, I have also read and understand the requirements that activities, including height and weight requirements and restrictions, and understand that the participant will not be allowed to participate in applicable high-altitude programs if those requirements are not met. The participant has permission to engage in all high-altitude activities described, except as specifically noted by me or the health-care provider. If the participant is under the age of 16, 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: _____ Phone: _____
Name: _____ Phone: _____

Adults NOT Authorized to Take Youth to and From Events:

Name: _____ Phone: _____
Name: _____ Phone: _____



444-311
WEB FORM



Part B1: General Information/Health History

B1

Full name: _____ High-adventure base participant
 Registration No.: _____
 or email address: _____
 Date of birth: _____

Age: _____ Gender: _____ Height (inches): _____ Weight (lbs): _____
 Address: _____
 City: _____ State: _____ ZIP code: _____ Phone: _____
 Unit leader: _____ Unit leader's email: _____
 Council identifier: _____ Unit No.: _____
 Health/accident insurance Company: _____ Policy No.: _____

Please attach a photograph of both sides of the tentmate card, if you do not have tentmate insurance, name "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	Comments	Explain
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	Last blood a percentage and date: _____ Insulin pump? Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Hypertension (high blood pressure)	
<input type="checkbox"/>	<input type="checkbox"/>	Adult or congenital heart abnormality (abnormal pulse or rhythm)? List any surgery or any classes. Any heart surgery or procedure. Explain all "yes" answers.	
<input type="checkbox"/>	<input type="checkbox"/>	Family history of heart disease or any sudden heart-related death of a family member before age 50.	
<input type="checkbox"/>	<input type="checkbox"/>	Stroke/TIA	
<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune chronic disease	Last medical date: _____
<input type="checkbox"/>	<input type="checkbox"/>	Lung/respiratory disease	
<input type="checkbox"/>	<input type="checkbox"/>	COPD	
<input type="checkbox"/>	<input type="checkbox"/>	Back/musculoskeletal problems	
<input type="checkbox"/>	<input type="checkbox"/>	Menstrual/obstetric complications or bone issues	
<input type="checkbox"/>	<input type="checkbox"/>	Head injury/concussion/TBI	
<input type="checkbox"/>	<input type="checkbox"/>	Allergic diseases	
<input type="checkbox"/>	<input type="checkbox"/>	Epistaxis/nasal/sinusitis or ear/nose/throat infection	
<input type="checkbox"/>	<input type="checkbox"/>	Neurological/neurological disorders	
<input type="checkbox"/>	<input type="checkbox"/>	Mental disorders/behavioral and issues	
<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells and dizziness	
<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	
<input type="checkbox"/>	<input type="checkbox"/>	Seizures or epilepsy	Last medical date: _____
<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune/autoimmune problems	
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	
<input type="checkbox"/>	<input type="checkbox"/>	Skin issues	
<input type="checkbox"/>	<input type="checkbox"/>	Cholesterol and/or metabolic disorders	CSM? Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	List all surgeries and hospitalizations	Last surgery date: _____
<input type="checkbox"/>	<input type="checkbox"/>	List any other medical conditions not covered above	

Part B2: General Information/Health History

B2

Full name: _____ High-adventure base participant
 Registration No.: _____
 or email address: _____
 Date of birth: _____

Allergies/Medications
 DO YOU HAVE AN ALLERGIC REACTION? YES NO
 AUTOCLAVING Exp. date (if year) _____
 DO YOU HAVE AN ASTHMA MEDICAL DEVICE? YES NO
 INHALER Exp. date (if year) _____

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
<input type="checkbox"/>	<input type="checkbox"/>	Medication		<input type="checkbox"/>	<input type="checkbox"/>	Plants	
<input type="checkbox"/>	<input type="checkbox"/>	Food		<input type="checkbox"/>	<input type="checkbox"/>	Insect stings/bites	

List all medications currently used, including any over-the-counter medications.

Check here if no medications are currently taken. If additional space is needed, please list on a separate sheet and attach.

Medication	Dose	Frequency	Notes

YES NO This prescription medication administration is self-administered with these exceptions: _____
 Administration of the above medications is supervised by you/it by: _____
 Physician/Physician _____ MD/DO, NP, or PA (provide if possible) (provide name/credentials)

Bring enough medication 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 medications unless instructed to do so by your doctor.

Immunizations

The following immunizations are recommended. Vaccine immunization is required and must have been received within the last 10 years. If you had the disease, check the disease column and fill the date. If immunized, check yes and provide the year received.

Yes	No	Disease	Immunization	Year(s)
<input type="checkbox"/>	<input type="checkbox"/>	Tetanus		
<input type="checkbox"/>	<input type="checkbox"/>	Pertussis		
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A		
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B		
<input type="checkbox"/>	<input type="checkbox"/>	Meningococcal/diph.		
<input type="checkbox"/>	<input type="checkbox"/>	Polio		
<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox		
<input type="checkbox"/>	<input type="checkbox"/>	Measles A		
<input type="checkbox"/>	<input type="checkbox"/>	Measles B		
<input type="checkbox"/>	<input type="checkbox"/>	Mumps		
<input type="checkbox"/>	<input type="checkbox"/>	Scarlet		
<input type="checkbox"/>	<input type="checkbox"/>	Morax (d., MR)		
<input type="checkbox"/>	<input type="checkbox"/>	Exempler to immunizations (name required)		

Please list any additional information about your medical history:

DO NOT WRITE IN THIS BOX.
 Return to camp or special activity.
 Released by: _____
 Date: _____
 Further approval required? No Yes
 Reason: _____
 Approved by: _____
 Date: _____



Part C: Pre-Participation Physical

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

C

Full name: _____

Date of birth: _____

High-adventure leave participation:

Department No.: _____

or club position: _____

4 You are being asked to verify that you are eligible to participate in a Scouting experience. For individuals who will be attending a high-adventure program, including one of the national high-adventure leaves, please refer to the Supplemental Information on the following pages or the form provided by your product. You can also visit www.scouting.org/health-and-safety/leave to view this information online.

Please fill in the following information:

	Yes	No	Explain
Medical conditions to participate	<input type="checkbox"/>	<input type="checkbox"/>	

Yes	No	Allegation or Condition	Explain	Yes	No	Allegation or Condition	Explain
<input type="checkbox"/>	<input type="checkbox"/>	Medication		<input type="checkbox"/>	<input type="checkbox"/>	Pain	
<input type="checkbox"/>	<input type="checkbox"/>	Food		<input type="checkbox"/>	<input type="checkbox"/>	Food allergies	

Height (inches)	Weight (lbs)	MM	Blood Pressure	Pulse

	Normal	Abnormal	Explain Abnormalities
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	
Ears/nose/throat	<input type="checkbox"/>	<input type="checkbox"/>	
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	
Heart	<input type="checkbox"/>	<input type="checkbox"/>	
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	
Genitalia/urine	<input type="checkbox"/>	<input type="checkbox"/>	
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	
Other Issues	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	

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):

Yes	No	Explain
<input type="checkbox"/>	<input type="checkbox"/>	Meets height/weight requirements.
<input type="checkbox"/>	<input type="checkbox"/>	Has no uncontrolled heart disease, lung disease, or hypertension.
<input type="checkbox"/>	<input type="checkbox"/>	Has not had an allergic reaction, uncontrolled condition, or respiratory emergency in the last six months or undergone a heart or lung disease in the past six months.
<input type="checkbox"/>	<input type="checkbox"/>	Has no uncontrolled psychiatric disorders.
<input type="checkbox"/>	<input type="checkbox"/>	Has had no asthma in the last year.
<input type="checkbox"/>	<input type="checkbox"/>	Does not have poorly controlled diabetes.
<input type="checkbox"/>	<input type="checkbox"/>	If planning to scuba dive, does not have diabetes, asthma, or asthma.

Examiner's signature: _____ Date: _____

Examiner's printed name: _____

Address: _____

City: _____ State: _____ ZIP code: _____

Office phone: _____

Height/Weight Restrictions

If you exceed the maximum weight by height or weight in the following chart and your planned high-adventure activity will take you more than 40 miles away from an emergency vehicle accessible roadway, you may not be allowed to participate.

Maximum weight by height

Height (inches)	Max. Weight	Height (inches)	Max. Weight	Height (inches)	Max. Weight	Height (inches)	Max. Weight
49	100	55	160	70	220	76	260
50	120	56	161	71	225	77	265
51	140	57	162	72	230	78	270
52	160	58	163	73	235	79	275
53	180	59	164	74	240	80	280
54	200	60	165	75	245	81	285
55	220	61	166	76	250	82	290
56	240	62	167	77	255	83	295
57	260	63	168	78	260	84	300
58	280	64	169	79	265	85	305
59	300	65	170	80	270	86	310
60	320	66	171	81	275	87	315
61	340	67	172	82	280	88	320
62	360	68	173	83	285	89	325
63	380	69	174	84	290	90	330
64	400	70	175	85	295	91	335
65	420	71	176	86	300	92	340
66	440	72	177	87	305	93	345
67	460	73	178	88	310	94	350
68	480	74	179	89	315	95	355
69	500	75	180	90	320	96	360
70	520	76	181	91	325	97	365
71	540	77	182	92	330	98	370
72	560	78	183	93	335	99	375
73	580	79	184	94	340	100	380
74	600	80	185	95	345	101	385
75	620	81	186	96	350	102	390
76	640	82	187	97	355	103	395
77	660	83	188	98	360	104	400
78	680	84	189	99	365	105	405
79	700	85	190	100	370	106	410
80	720	86	191	101	375	107	415
81	740	87	192	102	380	108	420
82	760	88	193	103	385	109	425
83	780	89	194	104	390	110	430
84	800	90	195	105	395	111	435
85	820	91	196	106	400	112	440
86	840	92	197	107	405	113	445
87	860	93	198	108	410	114	450
88	880	94	199	109	415	115	455
89	900	95	200	110	420	116	460
90	920	96	201	111	425	117	465
91	940	97	202	112	430	118	470
92	960	98	203	113	435	119	475
93	980	99	204	114	440	120	480
94	1000	100	205	115	445	121	485
95	1020	101	206	116	450	122	490
96	1040	102	207	117	455	123	495
97	1060	103	208	118	460	124	500
98	1080	104	209	119	465	125	505
99	1100	105	210	120	470	126	510
100	1120	106	211	121	475	127	515



Prepared. For Life.™

680-301
478 Printing



High-Adventure Risk Advisory to Health-Care Providers and Parents

Phone: 575-379-2261 Website: www.philmontscoutranch.org

Philmont Scout Ranch Experience. The Philmont experience is not risk-free; however, by taking responsibility for one's own health and safety, and cooperating with staff, it's expected that most participants will have an enjoyable, safe Philmont experience.

Please call Philmont at 575-379-2261 if you have any questions. All participants and parents should review all materials and notices related to the experience they are planning to have at Philmont Scout Ranch.

Risk Advisory. Participants at Philmont should be physically fit, have proper clothing and equipment, be willing to follow instructions, work as a team with your crew, and take responsibility for your own health and safety. Each crew is required to have at least two members trained in wilderness first aid and CPR.

All staff members are trained in first aid and CPR. They can assist participants in recognizing and responding to accidents, injuries, and illnesses. However, rescue teams are affected by location, terrain, weather, or other circumstances and could be delayed for hours or even days in a wilderness setting.

Barometric/altimeter charts can include temperatures from 80 to 100 degrees, low humidity (20% to 30%), and frequent, sometimes severe, thunderstorms. For summer trails:

- Each participant must be able to carry 25% to 35% of their own body weight.
- Each participant must be able to hike 5 to 12 miles per day in a mountain wilderness.
- Elevation ranges from 6,500 to 12,000 feet over trails that are steep and rocky.

Dependent upon the Autumn Adventure itinerary, similar expectations are in effect.

During a Winter Adventure experience:

- Each participant will walk, ski, or snowshoe along snow-covered trails getting loaded toboggans or sleds for up to 8 miles (or more on a cross-country ski trail).
- Winter climate conditions can range from -20 to 80 degrees.

Food. If the diet described in the Guidebook to Adventure does not meet the participant's special dietary needs, contact Philmont directly. Visit the [wilderness dining page](#) for sample menus and menu instructions.

Immunizations. Each participant must have received a tetanus immunization within the last 10 years. Immunization against contagious disease is strongly recommended (including MMR, varicella, hepatitis A and B, and meningococcal disease). Participants who do not have immunizations because of medical issues or personal religious beliefs in accordance with New Mexico state law must complete a [Philmont Immunization Exemption Request Form](#).

Allergy or Anaphylaxis. People who have had an anaphylactic reaction from any cause will be required to have appropriate treatment (i.e., at least one epinephrine auto-injector) in sufficient quantity to last the entire trip. All members of the crew should know how to administer the auto-injector. If you do not bring an epinephrine auto-injector with you, you will be required to purchase one before you will be allowed to participate.

Philmont Scout Ranch

Medication. Each participant who needs medication must bring enough medicine for the duration of the trip. Be aware that insulin/food/activities, etc., can affect a medication's efficacy. It is not uncommon for participants to see more medication (particularly insulin and antibiotics) than anticipated due to unanticipated conditions faced on the trail.

Seizures (Epilepsy). The seizure disorder must be well-controlled by medication. A well-controlled disorder by one in which all seizures have passed without a seizure. Individuals with seizure conditions should familiarize others with signs and symptoms in the event that a seizure occurs in the backcountry.

High Blood Pressure. Upon arrival at Philmont, all adult participants may have their blood pressure checked. People diagnosed with hypertension should have controlled blood pressure before arriving Philmont and should continue their medications to keep the blood pressure at or near normal levels. Those individuals with a blood pressure consistently greater than 160/95 at Philmont may be kept off the trail.

Diabetes Mellitus. Participants with diabetes can have a successful Philmont experience by good planning prior to their trip. Both the person with diabetes and others in their crew or group need to be able to recognize signs of excessively high or low blood sugar. An insulin-dependent person who was diagnosed or had a change in delivery system (e.g., insulin pump) or dosage in the last six months is advised to consult with their physician before participating.

Asthma. Asthma must be well-controlled before participating at Philmont. Well-controlled asthma is defined as:

- The use of a rescue inhaler (albuterol) fewer than two times per week (except use for the prevention of exercise-induced asthma); weakened by asthma symptoms less than two times per month.
- Well-controlled asthma may include the use of long-acting bronchodilators, inhaled steroids, or oral medications such as Singulair.

You may not be allowed to participate if:

- You have asthma not controlled by medication; or
- You have been hospitalized/gone to the emergency room to treat asthma in the past six months; or
- You required treatment by oral steroids (prednisone) in the past six weeks.

All members of the crew should know how to assist in administering the rescue inhaler and where the inhaler is located. Any person who has avoided treatment for asthma in the past three years must carry a rescue inhaler on the trip. If you do not bring a rescue inhaler, you must purchase one before you will be allowed to participate.



800-351-6699
505-379-6699



Wilderness First Aid (WFA) Requirements

- **16-hour BSA approved course (e.g., ARC, ECSI)**
 - Usually run over a weekend
 - See DC Metro area providers handout
- **Current CPR certification required for WFA**
 - Often run in conjunction with WFA course (Fri or Sat)
 - Separate fee
- **PHILMONT requires TWO (2) crew members**
 - Consider one adult and one Scout
- **Plenty of courses offered but do NOT wait until June!**



WILDERNESS FIRST AID VENDORS LIST

BSA has identified providers recognized by the following three organizations as meeting BSA's requirements for WFA training: (1) [American Red Cross \(ARC\)](#), (2) [Emergency Care & Safety Institute \(ECSI\)](#), and (3) providers accredited by the [American Camp Association \(ACA\)](#). Here is a list of WFA course providers in the DC Metropolitan area who meet these standards:

PRACTITIONERS:

Campaign Pay It Forward (ARC)

www.campaignpayitforward.com, (833) 273-6263, info@campaignpayitforward.com

Center for Wilderness Safety (ACA)

www.wildsafe.org, (855) 505-1700 or (703) 444-9468 - Cliff Castleman - clifton@wildsafe.org

Emergency Response Training (ECSI)

www.onthetrailfirstaid.com, (410) 456-6861 - Saleena DeVore - saleena@onthetrailfirstaid.com

Emergency Training Resources (ECSI)

www.ETRsafety.com, (703) 771-6092, info@ETRsafety.com

MEDIC SOLO Disaster + Wilderness Medical School (ACA)

www.solowfa.com, (434) 326-4697, courses@solowfa.com

NOLS + REI-Washington DC (ACA)

<https://www.rei.com/events/a/outdoor-skills-wilderness-medicine>

Outdoor Preparedness Initiative-NCAC (ARC)

<https://scoutingevent.com/082-63544>, Richard Holtslander- richard.holtslander@gotogoshen.org

Wilderness Safety Council (ACA)

www.wfa.net, (703) 836-8905, Chris Tate - chris@wfa.net

OTHERS:

Troop 1430 – South Riding VA (ECSI)

Dallas Cecil - dkcecil@earthlink.net - (571) 969-1592

Offers classes to BSA units only, in the evenings at low cost. CPR certification is not provided.

Troop 420 – Leonardtown MD (ECSI)

Richard Price - richiebob2@gmail.com - (301) 884-8962

Venturing Crew 80 – Alexandria VA (ARC)

Michael Martin (Associate Advisor) - CPRAEDFAWRFA@comcast.net

Periodically offers Wilderness and other First Aid classes at reduced rates to BSA units.

REGISTER FOR ALL CLASSES ON THE VENDORS' WEBSITE



COVID Mitigation @Philmont

- **Mitigation Procedures Remain from 2022**
 - Complete Vax or Neg Test w/in 3-7 days
 - Masking, social distancing & cohort guidance
 - Contact tracing
- **3 Forms Req'd:**
 - Pre-Screening
 - Consent
 - Code of Conduct
- **Lead Advisor: Check w/Philmont for Updates**



HINTS on FORMS

- PHILMONT GATEWAY
 - Crew online “Portal” – completed by Lead Advisor
 - Enter crew roster, upload Health/Medical Record & training dates
- BRING HARD COPIES to PHILMONT
 - Health/Medical Records including copy of insurance card
 - All WFA, CPR and other training cert’s
- ALL SHOULD HAVE CURRENT H/MR FOR HIKES
 - Give to Lead Advisor NOW for review, discussion of concerns

