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: _____

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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

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

Yes	No	Had Disease	Immunization	Date(s)
☐	☐		Tetanus	
☐	☐		Pertussis	
☐	☐		Diphtheria	
☐	☐		Measles/mumps/rubella	
☐	☐		Polio	
☐	☐		Chicken Pox	
☐	☐		Hepatitis A	
☐	☐		Hepatitis B	
☐	☐		Meningitis	
☐	☐		Influenza	
☐	☐		Other (i.e., HIB)	
☐	☐		Exemption to immunizations **(form required)**	

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: _____

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Participant Health Screening Checklist

For use at events & outings as well as meetings

MARIN COUNCIL
Boy Scouts of America

Name: _____ Unit # _____ Date: _____

All participants (youth and adult) should use this checklist or similar screening to mitigate possible exposure to communicable diseases. This checklist should be completed twelve hours or less before the start of the activity. It should be collected and reviewed as participants arrive.

Part 1: Higher Risk for Serious Illness

If you are at higher risk as defined by CDC guidelines, it may be recommended that you stay home unless you have approval from your health care provider. The CDC describes those at higher risk for severe illness from COVID-19 as those who are / have:

- 65+ years old
- Obesity
- Smoker
- Respiratory issues (lung disease, severe asthma, cystic fibrosis)
- Circulation issues (high blood pressure, coronary disease)
- Diabetes
- Immunosuppression
- Chronic kidney or liver disease

Part 2: Recent Interactions

☐ Yes ☐ No Do you have COVID-19 or are you currently awaiting results of a COVID-19 Test?

☐ Yes ☐ No Have you been in contact with anyone who has COVID-19 or is ill with a respiratory illness but has not been test for COVID-19 in the last 14 days?

☐ Yes ☐ No Do you (or someone you have been in close contact with) live, work, or travel in an area with a large outbreak of COVID-19 disease (hot spot) in the last 14 days?

☐ Yes ☐ No Are you (or anyone you have been in close contact with) under current advisement by public health authorities to quarantine or self-isolate?

If any question is answered – YES, the individual should stay home.

Part 3: Health Screening

Do you have any of the following symptoms which are related to a new / recent illness and cannot be attributed to another health condition?

☐ Yes ☐ No Fever or chills
☐ Yes ☐ No Cough
☐ Yes ☐ No Shortness of breath
☐ Yes ☐ No Fatigue, muscle or body aches
☐ Yes ☐ No Sore throat
☐ Yes ☐ No Congestion, runny nose
☐ Yes ☐ No New loss of taste or smell
☐ Yes ☐ No Headache
☐ Yes ☐ No Nausea or vomiting
☐ Yes ☐ No Diarrhea

If any question is answered – YES,
the individual should stay home until cleared by a physician.

Marin Sierra 2021

Minor Activity Release Form

(For youth under 18 years old)

This specific and current form must be used and be present on camp property at Camp Marin Sierra summer camp. *No other form will be accepted.* Scouts without this form will not be able to participate in the below-listed activities. This form should be fully completed and brought with the troop to camp to be submitted with health forms during the camp orientation at the health lodge.

Week (check one): ❑ July 4–10 ❑ July 11–17 ❑ July 18–24 ❑ July 25–31

Scout's name_____Troop #_____Date of birth_____

Please Note: While not required, the Marin Council prefers the signatures of both parents/guardians and, for any selection that is chosen, the initials of both.

The undersigned consent that the rifle, shotgun, or archery instructor of the Marin Council Boy Scouts may furnish a BSA approved firearm or archery equipment along with ammunition, to the above-named minor for the purpose of instruction in the safe handling and shooting of firearms or archery equipment and related activities. Please initial each box below where permission is granted for the minor to participate. This consent expires automatically on August 1, 2021.

_____ _____ Archery _____ _____ Rifle (.22 caliber) _____ _____ Shotgun _____ _____ Black powder

The above-named minor may participate in the normal activities of the camp program including, but not limited to, swimming, boating, games, and hiking. In addition to these, permission is granted to participate in the following special activities listed below if they are available at camp, some of which may be off site. Please initial those for which permission is granted for the minor to participate.

_____ _____ COPE *(with Scoutmaster approval)* _____ _____ Rock climbing *(with Scoutmaster approval)*

_____ _____ I/we do *not* give the above-named minor permission to participate in (be specific):_____

_____

Please circle whether parent or guardian.

Parent/Guardian #1 signature _____ Initials _____ Date _____

Name *(please print)*_____

Address _____ City _____ State _____ Zip _____

Primary Phone _____ ❑ Home ❑ Work ❑ Cell Alt. phone _____ ❑ Home ❑ Work ❑ Cell

Parent/Guardian #2 signature _____ Initials _____ Date _____

Name *(please print)* _____

Address _____ City _____ State _____ Zip _____

Primary Phone _____ ❑ Home ❑ Work ❑ Cell Alt. phone _____ ❑ Home ❑ Work ❑ Cell