# **Part A:** Informed Consent, Release Agreement, and Authorization

PACK 566 **A**

Full name: _____

Date of birth: _____

### 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

PACK 566 **B1**

Full name: _____

Date of birth: _____

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

Pack 566 **B2**

Full name: _____

Date of birth: _____

## 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 | Yes | No | Allergies or Reactions | Explain |
|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Medication | | ☐ | ☐ | Plants | |
| ☐ | ☐ | Food | | ☐ | ☐ | 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 | |
| ☐ | ☐ | | Covid19 Vacinated on Enter Date:---> | |
| ☐ | ☐ | | 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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**SILICON VALLEY MONTEREY BAY COUNCIL**
**Boy Scouts of America**
COVID-19 Participant Agreement

Your safety and the safety of all our members, volunteers, and employees is the Silicon Valley Monterey Bay Council's top priority. In light of COVID-19, we are taking additional precautions for Scouting activities on top of our long-established health and safety measures.

First, our Council Risk Management Committee and health supervisor, a physician, is coordinating with state and local public health departments to ensure we understand and follow applicable public health guidance to mitigate the risk of COVID-19 at in-person Scouting activities.

Our mitigation plan includes:

- Pre-attendance awareness of COVID-19 and safety protocols;
- Pre-activity health screening conducted by your unit prior to travel to the activity;
- Face coverings acceptable to the health officer (e.g., neckerchiefs or gaiters are generally considered insufficiently protective face coverings) must be worn by participants while traveling to the activity, throughout the time they participate in the activity, and while returning home from the activity;
    - If the activity is for more than one day, participants must bring and wear a clean face covering for each day;
- Social distancing will be practiced to the extent possible; we also know the very nature of Scouting activities makes social distancing difficult in many situations and impossible in others.
- Health screening upon your arrival at the activity conducted by our health officers;
    - Note: Because of the contagious nature of COVID-19, should anyone in the unit not pass the arrival screening, the entire unit will not be allowed to participate in the activity;
- Limits on visitors at the activity;
    - All visitors will be screened upon arrival before entry to the activity;
- Hand Hygiene reminders throughout activity experience;
    - Extra handwashing /sanitizer stations throughout the activity;
    - Dedicated staff to clean and disinfect high-touch surfaces and shared program equipment;
- An emergency response plan that includes isolation and quarantine protocol should a person at the activity develop symptoms of COVID-19 or other communicable disease;
- Check-ins with each participants, either individually or through unit leaders, one week and two weeks after the unit leaves the activity to determine if any participants have developed symptoms.

These precautions are important, but they do not remove the potential for exposure to COVID-19 or any other illness while at this Scouting activity. Some people with COVID-19 show no signs or symptoms of illness but can still spread the virus, and people may be contagious before their symptoms occur. These factors mean that an infected person may pass the required health screenings and be allowed to participate.

Information from the Centers for Disease Control and Prevention (CDC) states that older adults and people of any age who have serious underlying medical conditions are at higher risk for severe illness from COVID-19. *If you are in this group, please ensure you have approval from your health care provider prior to attending this activity.*

**Assumption of Risk Agreement**

I acknowledge that I am aware of the contagious nature of COVID-19 and that I will take all reasonable public health precautions to avoid becoming infected by it, including avoiding crowded places, wearing a face covering, practicing social distancing of at least six feet, hand hygiene by frequent hand washing or use of hand sanitizer with at least 60% alcohol, and by limiting in-person contact with others to the maximum extent possible, particularly those who are not following the foregoing public health precautions.

I voluntarily assume the risk that I may be exposed to or infected by COVID-19 by attending this activity, and that such exposure or infection may result in personal injury, illness, permanent disability, and, in extreme cases, death. I understand that the risk of becoming exposed to or infected by COVID-19 may result from the actions, omissions, or negligence of myself and others.

I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to myself (including, but not limited to, personal injury, disability, and death), illness, damage, loss, claim, liability, or expense of any kind that I may experience or incur in connection with ("Claims").

I hereby release, hold harmless, and covenant not to sue the Silicon Valley Monterey Bay Council, the Boy Scouts of America, and each of their employees, volunteers, agents, and representatives (collectively, "Released Parties") from any and all Claims, including all liabilities, claims, actions, damages, obligations, costs or expenses of any kind arising out of or relating thereto. I understand and agree that this release includes any Claims based on the actions, omissions, or negligence of the Released Parties, whether a COVID-19 infection occurs before, during, or after participation in program.

This Assumption of Risk Agreement shall be construed under the laws of the state of California. If any provision of this Assumption of Risk Agreement is deemed unenforceable by law, (a) the Released Parties shall have the right to modify such provision to the extent necessary to be deemed enforceable, and (b) all other provisions of this Assumption of Risk Agreement shall remain in full force and effect.

I HAVE READ THIS WAIVER, UNDERSTAND IT, AND AGREE TO BE BOUND BY IT.

| | |
|---|---|
| Parent Signature<br>(if Participant is under the age of 18) | Signature of Participant |
| Printed Name | Printed Name |
| Date | Date |

Pack 566