Maine High Adventure (MHA)
Katahdin Area Council, Boy Scouts of America

HEALTH AND MEDICAL RECORD

In order to participate at MHA, this medical form, completed, is required at check-in.

Name: ________________________ Date of birth: __________

Address: ________________________

City/Town: ________________________ State: ___ Zip: __________

THE MINIMUM AGE REQUIREMENT FOR PARTICIPATION IN MHA IS 13 BEFORE JAN. 1 OF THE PARTICIPATORY YEAR.

In case of emergency, notify:
Name: ________________________ Relationship: ________________

Address: ________________________

Phone numbers: home: ________________ work or other: ________________

Alternate contact name: ________________ phone number: ________________

This health and medical record, including limitations indicated, is valid for participation in activities for 12 months after date of completion by physician. Should questions or problems arise, participants may be asked to be medically re-evaluated after their arrival at Maine High Adventure. Maine High Adventure, BSA recognizes the right of a person to decline this medical evaluation, immunizations, and/or medical treatment for reasons of religion or conscience. However, a written statement stating this declination is required from any participant, or parent/guardian of a minor participant, who decline for any such reason. This statement must also indicate that the participant is believed to be free of contagious disease and physically capable of tolerating very strenuous physical activity of an outdoor adventure nature.

ACKNOWLEDGMENT/AUTHORIZATION STATEMENT

I, the undersigned, have read and understood this entire form (jacket and insert) and the MHA Participant Manual. The health history of this participant is accurate and person herein described has permission to engage in MHA activities, except as specifically noted by me or the physician completing the examination. If I become incapable of making decisions regarding care, and/or the emergency contact person identified above cannot be reached, I hereby give permission to the physician selected by MHA or the adult advisor in charge of this group, to treat, hospitalize, secure anesthesia, or to order injection, surgery, or other treatment for the person described herein, and the MHA physician has permission to obtain all information connected with treatment by a physician, or other treatment facility.

Signature*: ________________________ Date: __________
* (participant, if 18 or older, parent/guardian if participant is under 18)