

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

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

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 <input type="checkbox"/> No <input type="checkbox"/>
		Hypertension (high blood pressure)	
		Adult or congenital heart disease/heart attack/chest pain (anginal)/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 <input type="checkbox"/> No <input type="checkbox"/>
		List all surgeries and hospitalizations	Last surgery date: _____
		List any other medical conditions not covered above	



## Part B2: General Information/Health History

Full name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

### High-adventure base participants:

Expedition/crew No.: \_\_\_\_\_

or staff position: \_\_\_\_\_

### Allergies/Medications

DO YOU USE AN EPINEPHRINE ☐ YES ☐ NO  
 AUTOINJECTOR (e.g. EpiPen)? Exp. date (if yes) \_\_\_\_\_

DO YOU USE AN ASTHMA RESCUE ☐ YES ☐ NO  
 INHALER? 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.**

### Immunizations

The required immunizations are above the bold line. The others are recommended. If immunized, check yes and provide the date. If you have had the disease, provide the date you had the disease. If you have a medical exemption for immunizations, have your health-care provider state the reason on Part C.

Y	N	Had Disease	Positive titers	Immunization	Date(s)
				<b>Tetanus/ Diphtheria</b>	
				<b>Pertussis (Whooping Cough)</b>	
				<b>Measles/mumps/rubella</b>	
				<b>Polio</b>	
				<b>Chicken Pox</b>	
				Hepatitis A	
				Hepatitis B	
				Influenza	
				Haemophilus influenza type b (HIB)	
				Human Papilloma Virus (HPV)	
				Meningococcus conjugate	
				Meningococcus Type B	
				Shingles	
				COVID-19	
				Other	

**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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## Part C: Pre-Participation Physical

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

Full name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

### High-adventure base participants:

Expedition/crew No.: \_\_\_\_\_

or staff position: \_\_\_\_\_



You are being asked to certify that this individual has no contraindication for participation in a Scouting experience. For individuals who will be attending a high-adventure program, including one of the national high-adventure bases, please refer to the supplemental information on the following pages or the form provided by your patient. You can also visit [www.scouting.org/health-and-safety/ahmr](http://www.scouting.org/health-and-safety/ahmr) to view this information online.

### Please fill in the following information:

	Yes	No	Explain
Medical restrictions to participate			
Medical exemption for immunizations			

Yes	No	Allergies or Reactions	Explain
		Medication	
		Food	

Yes	No	Allergies or Reactions	Explain
		Plants	
		Insect bites/stings	

Height (inches)	Weight (lbs.)	BMI	Blood Pressure	Pulse
			/	

	Normal	Abnormal	Explain Abnormalities
Eyes			
Ears/nose/throat			
Lungs			
Heart			
Abdomen			
Genitalia/hernia			
Musculoskeletal			
Neurological/behavioral disorders			
Skin issues			
Other			

### 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):

True	False	Explain
		Meets height/weight requirements. (See table below.)
		Has no uncontrolled heart disease, lung disease, or hypertension.
		Has not had an orthopedic injury, musculoskeletal problems, or orthopedic surgery in the last six months or possesses a letter of clearance from his or her orthopedic surgeon or treating physician.
		Has no uncontrolled psychiatric disorders.
		Has had no seizures in the last year.
		Does not have poorly controlled diabetes.
		If planning to scuba dive, does not have diabetes, asthma, or seizures.

Examiner's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Examiner's printed name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP code: \_\_\_\_\_

Office phone: \_\_\_\_\_

### Height/Weight Restrictions

If you exceed the maximum weight for height as explained in the following chart and your planned high-adventure activity will take you more than 30 minutes away from an emergency vehicle/accessible roadway, you may not be allowed to participate.

#### Maximum weight for height:

Height (inches)	Max. Weight	Height (inches)	Max. Weight	Height (inches)	Max. Weight	Height (inches)	Max. Weight
60	166	65	195	70	226	75	260
61	172	66	201	71	233	76	267
62	178	67	207	72	239	77	274
63	183	68	214	73	246	78	281
64	189	69	220	74	252	79 and over	295



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Website: [jamboree.scouting.org](http://jamboree.scouting.org)

The following supplemental information is for Scouts, Scouters, parents/guardians, and examining health-care providers of every participant in the 2026 National Jamboree. Attendees who do not meet these guidelines may not be able to participate in the Jamboree or certain Jamboree programs. Attendees must seek specific clearance PRIOR to the Jamboree if they do not meet these guidelines, or they might be sent back home at their own expense.

**Important Process Note.** If you answer “Yes” to any advisory question or have a medical condition listed below, discuss it with your examining provider during your annual physical when completing the Scouting America Annual Health and Medical Record (AHMR) Parts A, B1, B2, and C. Your provider’s clinical guidance as documented in the AHMR and any attached notes will inform participation decisions. Please do not contact the Summit Bechtel Reserve for Jamboree medical questions.

**Proactive Screening.** The Jamboree Health and Wellness Medical Services leadership will review AHMRs to identify participants who might be at increased risk of illness and/or injury at the Jamboree and will reach out accordingly in Spring 2026 to coordinate any additional information or planning.

**Activities and Physical Demands.** Jamboree activities are listed at [jamboree.scouting.org](http://jamboree.scouting.org) and can be physically, mentally, and emotionally demanding (for example: mountain biking, climbing, high-adventure challenge courses, whitewater rafting, range/target sports, and more). Participants should arrive physically prepared for their selected activities. Expect significant daily walking on uneven terrain (often 5 to 7 miles a day) and summer heat with a high heat index. **Be prepared.**

**Safety and Required Documentation.** Medical preclearance via a complete AHMR Parts A, B1, B2, C, and this risk advisory is required for participation in Jamboree activities. AHMR Parts A, B1, B2, and this risk advisory are completed in CampDoc. You should also have a paper copy to travel with your contingent. Part C must be signed by your examining provider and uploaded by the participant into the CampDoc AHMR.

- The limitations and requirements for the chronic conditions that follow may apply to any Jamboree program.
- The Jamboree Health and Wellness team may request additional documentation (for example: specialist letters, recent test results) based on your AHMR and provider notes.
- Participants may be subject to an arrival medical recheck (for example: vitals, verification of required medications, and equipment).
- For questions, work through your unit health and wellness leader and council Jamboree contacts; **do not contact the Summit Bechtel Reserve**. More information will be shared in the coming months for the unit health and wellness leader that is required for each 40-person unit. They should be the first point of contact and will understand who to ask next if they cannot answer your question.
- Failure to meet guidelines, bring required medications and equipment, or provide requested documentation may result in restricted participation or inability to participate.

**Immunizations.** Each participant must have received a tetanus immunization within the last 10 years. Recognition is given to those without a specific immunization due to philosophical, political, or religious exemptions. Complete the Immunization Exemption Request form in CampDoc Part B — Immunizations.

**Condition Specific Guidance.** In all cases below, bring enough non-expired medication/supplies for the entire event (including travel to and from) and ensure your AHMR includes your provider’s current instructions. Discuss all “Yes” items with your examining provider during your annual physical.

**How to Get Help.** Do not email or call the Summit. Start with your unit health and wellness leader and then your council Jamboree coordinator with questions.

- Use the CampDoc link in [jamboree.scouting.org](http://jamboree.scouting.org) to upload AHMR info; if the Jamboree medical team needs more information, they will contact you (Spring 2026 for higher-risk reviews).
- For program descriptions and preparation guidance, visit [jamboree.scouting.org](http://jamboree.scouting.org).

**Allergy or Anaphylaxis.** Prior anaphylaxis (any cause) requires always carrying an **unexpired** epinephrine autoinjector or nasal spray. If an autoinjector is listed on the AHMR, **you must bring it**. All unit leaders, including the unit health and wellness leader, should know the location and use; the medical team may verify possession and currency.

**Asthma.** Asthma must be well controlled (rescue inhaler used fewer than two times a week except pre-exercise; nighttime symptoms fewer than two times a month). Participation in certain activities may not be allowed if asthma is uncontrolled, an ER visit or hospitalization was made in the past six months, or oral steroids were needed in the past six months. Bring enough daily medications and a non-expired rescue inhaler; unit health and wellness leaders know how to assist.

**Seizure Disorder.** Participation is possible if well controlled, generally 12 months seizure-free. Exceptions may be considered on an individual basis based on provider documentation. Be prepared to provide neurology clearance if requested by Jamboree medical reviewers.

**Recent Musculoskeletal Injuries or Orthopedic Surgery.** High walking loads and elevation changes place strain on joints and spine. Individuals with chronic musculoskeletal problems should consider if participation in Jamboree activities is advisable for them. Orthopedic injury or surgery within six months may require an additional clearance letter from the treating clinician specifying limitations and current functional status. The medical team may request specific information in the clearance letter (for example: weight-bearing status, brace use, physical therapy progress).

**Psychological and Emotional Health Considerations.** A diagnosis alone does not preclude participation in the Jamboree. **Do not stop psychiatric medications.** Given environmental stressors, discuss stability with your provider — especially if there is a history of hospitalization or suicidality. Jamboree medical reviewers may request additional context from your clinician and require additional screening prior to arriving at the Jamboree.

**Diabetes.** Diabetes does not automatically exclude participation in the Jamboree. Newly insulin-dependent participants diagnosed within 12 months or with delivery-system changes within six months generally require a provider clearance letter and a recent HbA1c (within six months). The unit health and wellness leader will be familiar with recognition and response to diabetic emergencies.



Website: [jamboree.scouting.org](http://jamboree.scouting.org)

**Hypertension (High Blood Pressure).** The condition must be well controlled with current medications (target less than 140/90). Confirm prescribed medication doses with your prescribing clinician prior to attending. The Jamboree Health and Wellness Medical Services Team may verify blood pressure against AHMR documentation and ask for an arrival medical check.

**Smoking.** Smoking and vaping are not permitted during Scouting America activities. Current smokers are strongly encouraged to attempt to quit smoking and discuss with their provider prior to the event.

**Medication Management and Storage.** Bring sufficient non-expired medications for the entire event, including travel to and from the event. The unit health and wellness leader will assist with medication schedules. Medications must be secured in locked storage. Emergency meds (inhalers, epinephrine) must remain with the individual. Refrigeration is available for medications requiring cold storage. Controlled substances must be declared at medical check-in and stored per applicable laws. If you have special storage needs, note them with your unit health and wellness leader in advance so arrangements can be made on site.

**Other Medical Considerations.** Participants with the conditions below should undergo evaluation by their physician to determine safety for vigorous activity and prolonged exertion in summer heat. Be prepared to provide recent results or letters if requested.

1. Chest pain requiring emergency department or cardiology evaluation within six months
2. Any myocardial infarction (heart attack)
3. Cardiac stent or angioplasty for blocked blood vessels within one year
4. Family history of heart disease or sudden death before age 50
5. Congestive heart failure
6. Any heart surgery (for example: coronary artery bypass grafting, valve replacement, ASD/VSD repair)
7. Stroke, transient ischemic attacks (TIA), ruptured aneurysm, or subarachnoid hemorrhage
8. Claudication (exercise-induced leg pain due to arterial disease)
9. Uncontrolled diabetes (for example: HbA1c above 9)

**Note:** Physical exertion at the Jamboree could precipitate cardiac or neurologic events in susceptible individuals. Provider clearance and individualized plans are essential.

**Weight Limits.** Weight limit guidelines are used because individuals who are overweight have a greater risk of heart disease, high blood pressure, stroke, altitude sickness, sleep problems, and injuries. These guidelines are for all Scouting **high-adventure activities**. Each participant's weight must be at or less than the maximum acceptable weight in the height/weight chart. Anyone exceeding the maximum weight for their height will require further review by the Jamboree Health and Wellness Team. Staff will use their judgment to determine whether those who exceed the maximum acceptable weight for their height can participate.

Any participant (regardless of program) weighing over 250 pounds will be restricted from participating in all aerial activities. There are no exceptions to this cutoff.

**Whitewater Rafting:** For this activity, participants must meet the height/weight chart. Exceptions will be considered based on age, BMI, and medical comorbidities. No one over 300 pounds will be permitted to participate in this activity. Please note, exceptions are limited by body morphology, as each participant must appropriately fit in a Type III PFD according to manufacturer specifications.

Height (inches)	Max. Weight	Height (inches)	Max. Weight
60	166	70	226
61	172	71	233
62	178	72	239
63	183	73	246
64	189	74	252
65	195	75	260
66	201	76	267
67	207	77	274
68	214	78	281
69	220	79 and over	295

