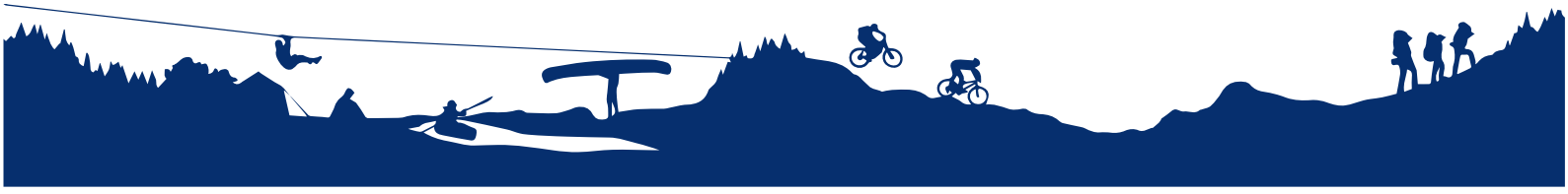
RESTARTING SCOUTING

SUPPLEMENTAL MEDICAL PERMISSION FORM

[REQUIRED FOR VULNERABLE CLASSES AND THOSE OVER 60 YEARS]

S·A·F·E

BOY SCOUTS OF AMERICA
CALIFORNIA INLAND EMPIRE COUNCIL



CALIFORNIA INLAND EMPIRE COUNCIL, BOY SCOUTS OF AMERICA

SUPPLEMENTAL MEDICAL PERMISSION

This part must be completed by a certified and licensed physician (MD, DO), nurse practitioner, or physician assistant.

Full name: _____

Date of birth: _____

Unit (Pack, Troop, Crew, Post) No.: _____

Unit Position: _____

Examiner's Certification: I certify that I have reviewed the above-named person's health history and have examined such person and find no contraindications for participation in any Scouting Activities and Events. Among other things, I have discussed with the above-named person risks associated with COVID-19 as well as the personal health, safety, and hygiene practices that are appropriate at this time.

The above-named person has the following conditions which are known to cause vulnerability to COVID-19 (check all that apply), but such conditions do not preclude such person from participating in any Scouting Activities and Events:

Age 60 or older: ☐ Yes ☐ No

Immunocompromised: ☐ Yes ☐ No

Underlying medical conditions ☐ Yes ☐ No
(such as chronic lung disease, moderate to severe asthma, heart conditions, conditions that can cause a person to be immunocompromised (including cancer treatment, smoking, bone marrow or organ transplantation, immune deficiencies, poorly controlled HIV or AIDS, and prolonged use of corticosteroids and other immune weakening medications), obesity, diabetes, chronic kidney disease and liver disease):

Examiner's signature: _____

Examiner's printed name: _____

Physician _____ NP _____ PA _____

Address: _____

City: _____

State: _____

ZIP code: _____

Office phone: _____

Date: _____