

Cub Scout Adventure Camp AND Webelos Resident Camp Registration Form

**PLEASE ATTACH
PHOTO OF CUB
SCOUT HERE**

I am attending:

___ Webelos Resident Camp

___ Cub Scout Adventure

Rank you will be working on this summer:

Tiger Cub
Bear

Wolf
Webelos

**Webelos Resident Camp
June 11-13
Muskingum Valley Scout Reservation**

Fees: \$80 if paid by May 14
\$90 if paid after May 14th at office
\$100 if paid first day of camp

This is my First Second Third Fourth
year attending adventure camp.
**All those attending camp will be provided
with Boy Scout camp tents

**Cub Scout Adventure Camp
July 30-August 1
Muskingum Valley Scout Reservation**

Fees: \$80 if paid by June 25
\$90 if paid after June 25th at office
\$100 if paid first day of camp

This is my First Second Third Fourth
year attending adventure camp.
I will: Bring my own tent Need a tent

Name: _____ Age _____

Address: _____ Pack Number: _____

City/State/Zip: _____

Parent or Guardian: _____

Daytime or Cell Phone : _____ E-Mail: _____

Secondary Emergency contact:

Name: _____ Relation: _____

Phone: _____

T-Shirt (included in cost of camp) size needed:

YM (10-12) YL (14-16) Small Medium Large X-Large

Additional T-shirts are available:

_____ # of additional tee shirts needed @ \$12.00 ea. (up to Adult XL) Size: _____

_____ # of additional tee shirts needed @ \$14.00 ea. (Adult 2XL - 3XL) Size: _____

**RETURN THIS FORM and parts A and C of the Annual BSA Health and Medical Record TO YOUR PACK'S SUMMER
CAMP COORDINATOR. ALL APPLICATIONS MUST BE TURNED IN TOGETHER.**

Annual BSA Health and Medical Record

Part A

GENERAL INFORMATION

Name _____ Date of birth _____ Age _____ Male Female
 Address _____ Grade completed (youth only) _____
 City _____ State _____ Zip _____ Phone No. _____
 Unit leader _____ Council name/No. Muskingum Valley Council/467 Unit No. _____
 Social Security No. (optional; may be required by medical facilities for treatment) _____ Religious preference _____
 Health/accident insurance company _____ Policy No. _____

**ATTACH A PHOTOCOPY OF BOTH SIDES OF INSURANCE CARD (SEE PART C).
 IF FAMILY HAS NO MEDICAL INSURANCE, STATE "NONE."**

In case of emergency, notify:

Name _____ Relationship _____
 Address _____
 Home phone _____ Business phone _____ Cell phone _____
 Alternate contact _____ Alternate's phone _____

MEDICAL HISTORY

Are you now, or have you ever been treated for any of the following:

| Yes | No | Condition | Explain |
|-----|----|--|---------|
| | | Asthma | |
| | | Diabetes | |
| | | Hypertension (high blood pressure) | |
| | | Heart disease (i.e., CHF, CAD, MI) | |
| | | Stroke/TIA | |
| | | COPD | |
| | | Ear/sinus problems | |
| | | Muscular/skeletal condition | |
| | | Menstrual problems (women only) | |
| | | Psychiatric/psychological and emotional difficulties | |
| | | Learning disorders (i.e., ADHD, ADD) | |
| | | Bleeding disorders | |
| | | Fainting spells | |
| | | Thyroid disease | |
| | | Kidney disease | |
| | | Sickle cell disease | |
| | | Seizures | |
| | | Sleep disorders (i.e., sleep apnea) | |
| | | GI problems (i.e., abdominal, digestive) | |
| | | Surgery | |
| | | Serious injury | |
| | | Other | |

Allergies or Reaction to:

Medication _____
 Food, Plants, or Insect Bites _____

Immunizations:

The following are recommended by the BSA. Tetanus immunization must have been received within the last 10 years. If had disease, put "D" and the year. If immunized, check the box and enter the year received.

| Yes | No | Date |
|--------------------------|--------------------------|-------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Tetanus _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Pertussis _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Diphtheria _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Measles _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Mumps _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Rubella _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Polio _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Chicken pox _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis A _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis B _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Influenza _____ |

Exemption to immunizations claimed.

(For more information about immunizations, as well as the immunization exemption form, see *Scouting Safely on Scouting.org.*)

MEDICATIONS

List all medications currently used. (If additional space is needed, please photocopy this part of the health form.) Inhalers and EpiPen information must be included, even if they are for occasional or emergency use only.

| | | |
|--|--|--|
| Medication _____ Strength _____ Frequency _____ Reason for medication _____ Approximate date started _____ Temporary <input type="checkbox"/> Permanent <input type="checkbox"/> | Medication _____ Strength _____ Frequency _____ Reason for medication _____ Approximate date started _____ Temporary <input type="checkbox"/> Permanent <input type="checkbox"/> | Medication _____ Strength _____ Frequency _____ Reason for medication _____ Approximate date started _____ Temporary <input type="checkbox"/> Permanent <input type="checkbox"/> |
| Medication _____ Strength _____ Frequency _____ Reason for medication _____ Approximate date started _____ Temporary <input type="checkbox"/> Permanent <input type="checkbox"/> | Medication _____ Strength _____ Frequency _____ Reason for medication _____ Approximate date started _____ Temporary <input type="checkbox"/> Permanent <input type="checkbox"/> | Medication _____ Strength _____ Frequency _____ Reason for medication _____ Approximate date started _____ Temporary <input type="checkbox"/> Permanent <input type="checkbox"/> |

NOTE: Be sure to bring medications in the appropriate containers, and make sure that they are NOT expired, including inhalers and EpiPens. You SHOULD NOT STOP taking any maintenance medication.

Emergency contact No.:

Allergies:

DOB:

Last name:

Part C

Parental Informed Consent and Hold Harmless/Release Agreement

I understand that participation in Scouting activities involves a certain degree of risk. I have carefully considered the risk involved and have given consent for myself or my child to participate in these activities. I understand that participation in these activities is entirely voluntary and requires participants to abide by applicable rules and standards of conduct. I 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 claims or liability arising out of this participation.

I approve the sharing of the information on this form with BSA volunteers and professionals who need to know of medical situations that might require special consideration for the safe conducting of Scouting activities.

In case of an emergency involving me or my child, I understand that every effort will be made to contact the individual listed as the emergency contact person. 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 to the adult in charge 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.

- Without restrictions.
- With special considerations or restrictions (list)

Talent Release Form

I hereby assign and grant to the local council and the Boy Scouts of America the right and permission to use and publish the photographs/film/videotapes/electronic representations and/or sound recordings made of me or my child by the Boy Scouts of America, and I hereby release the Boy Scouts of America from any and all liability from such use and publication.

I hereby 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 Boy Scouts of America, and I specifically waive any right to any compensation I may have for any of the foregoing.

- Yes No

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.

Participant's name _____

Participant's signature _____

Parent/guardian's signature _____
(if under the age of 18)

Date _____

Attach copy of insurance card (front and back) here. If required by your state, use the space provided here for notarization.



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Irving, Texas 75015-2079
<http://www.scouting.org>



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Part C Last name: _____ DOB: _____