



BOY SCOUTS OF AMERICA

CUB SCOUT INVESTIGATORS

Day Camp 2008

Youth

Registration

2008 Day Camps
Check the camp you will attend.

Black Diamond
First Christian Church,
Macon
July 26, 9am - 9pm
Director - Bill Truitt

Boonslick
Stephens Lake Park
June 3 - 5, 9:00am - 4pm
(6pm - 9pm Tuesday)
Director - Greg Baker

Chariton Valley
Rothwell Park Shelter #3,
Moberly
July 7 - 11, 5:30pm - 8:30pm
Director - Beccy Winn

Five Rivers
Jaycee Cole County
Fairgrounds
June 9 - 12, 9am - 4pm
Director - Scott Woolstenhulme

Grand Prairie
Mexico- 4-H Fairgrounds
May 27 - 30, 9am - 3:30pm
Director - Terri Nordwald

Kinderhook
Hohn Scout Reservation, Laurie
July 28 - 31, 6pm - 9pm
Director - Janet Davis

Mark Twain
Hannibal's Huckleberry Park
July 8 - 11, 9am - 3pm
Director - Al Pabst

Osage Trails
Sedalia Rod & Gun Club
July 14 - 18, 6pm - 9pm
Director - Chris Koetting

DO NOT MAIL THIS DIRECTLY TO THE COUNCIL SERVICE CENTER!

PLEASE TURN REGISTRATION AND FEES IN AT YOUR APRIL PACK MEETING

PACK # _____ DISTRICT _____

NAME _____

ADDRESS _____

CITY/ZIP _____

PHONE _____ EMAIL _____

X _____

Signature of Parent or Guardian (required for processing)

<u>GRADE AS OF 1/1/08</u>	<u>SHIRT SIZE</u>
___ Kindergarten*	___ 10-12 (youth)
___ 1st	___ 14-16 (youth)
___ 2nd	___ Small (adult)
___ 3rd	___ Medium (adult)
___ 4th	___ Large (adult)
	___ XL (adult)

*(parent or adult partner must attend)

2008 DAY CAMP FEES

\$50.00 - by May 1st
\$55.00 - after May 1st

Amount Paid \$ _____

Check List

- Check your camp choice!
- Complete registration form, including health history on the reverse side.
- Enclose registration fee, make check payable to your local Cub Scout Pack.
- Turn registration over to Cubmaster
- **DO NOT mail to Council service center.**



PERSONAL HEALTH AND MEDICAL RECORD

CLASS 1 PERSONAL HEALTH AND MEDICAL HISTORY

(To be filled out annually by all participants)

To be filled out by parent, guardian, or adult participant. Please print in ink.

IDENTIFICATION

Name _____ Date of birth _____ Age _____ Sex _____

Name of parent or guardian _____ Telephone _____

Home address _____ City _____ State _____ Zip _____

Business address _____ City _____ State _____ Zip _____

If person named above is not available in the event of an emergency, notify

Name _____ Relationship _____ Telephone _____

Name _____ Relationship _____ Telephone _____

Name of personal physician _____ Telephone _____

Personal health/accident insurance carrier _____ Policy No. _____

Check all items that apply, **past or present**, to your health history. Explain any "Yes" answers.

ALLERGIES: Food, medicines, insects, plants Yes No Explain: _____

GENERAL INFORMATION:	Yes	No		Yes	No		Yes	No
ADHD (Attention-Deficit								
Hyperactivity Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions/seizures	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>

Explain: _____

Please list ALL medications taken in the 30 days **prior** to arrival at the Scouting activity where this form is to be used: _____

List any medications to be taken at camp: _____

List any physical or behavioral conditions that may affect or limit full participation in swimming, backpacking, hiking long distances, or playing strenuous physical games: _____

List equipment needed such as wheelchair, braces, glasses, contact lenses, etc.: _____

Immunizations: (Give date of last inoculation.)

Tetanus toxoid _____ Measles _____ Polio _____

Diphtheria _____ Mumps _____

Pertussis _____ Rubella _____

I give permission for full participation in BSA programs, subject to limitations noted herein.

In case of emergency, I understand every effort will be made to contact me (if participant is an adult, my spouse or next of kin). In the event I cannot be reached, I hereby give my permission to the licensed health-care practitioner selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child (or for me, if participant is an adult).

Date _____ Signature of parent/guardian or adult _____

Date updated _____ Signature of parent/guardian or adult _____

Date updated _____ Signature of parent/guardian or adult _____

Some hospitals require the parent/guardian signature to be notarized. Check with your BSA local council.