

# Caswell District Cub Scout (Youth) Registration Form

In order to register a Cub Scout for Twilight Camp, this form and the Medical/information sheet Class I must be filled out, in ink, for each Scout. The registration fee must accompany this form by June 22, 2009. Scouts registered after the sign up date will not be guaranteed a T-shirt upon arrival at camp. An adult partner must accompany each Tiger cub.

Pack Number \_\_\_\_\_ Caswell District

Cub Scout's Name \_\_\_\_\_ Birth date \_\_\_\_\_

Parent's email address: \_\_\_\_\_

**Circle the school grade your child will begin in September 2009: (Rank is for the upcoming year)**

1<sup>st</sup> (Tigers)    2<sup>nd</sup> (Wolves)    3<sup>rd</sup> (Bears)    4<sup>th</sup> (Webelos I)    5<sup>th</sup> (Webelos II)

Each scout will receive **one** free T-shirt for camp. **The T-shirt must be worn every day at camp.** Extra T-shirts may be purchased at Camp if available. Circle the appropriate T-shirt size:

**Circle One:**            YM            YL            AS            AM            AL

**Circle One:**            Swimmer    or    Non-swimmer

**Emergency Contact:** During the activity, parent(s) may be reached at

Parent/Guardian's name \_\_\_\_\_

Contact number(s) \_\_\_\_\_

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### Fee Schedule

Cub Scout.....\$55  
Late fee (after June 22) .....\$15 (Total of \$70)

**Total Enclosed** .....\$ \_\_\_\_\_

Charge card:    MC    Visa    Exp. Date \_\_\_\_ / \_\_\_\_

Card # \_\_\_\_\_

Name on Card \_\_\_\_\_

Please make checks payable to:            **ECC – BSA**

**Please return completed form and payment to Council Office:**

**ECC BSA  
PO Box 1698  
Kinston, NC 28503**

Name \_\_\_\_\_

Administration Use Only

Pack \_\_\_\_\_

Den \_\_\_\_\_

# PERSONAL HEALTH AND MEDICAL RECORD

## CLASS 1 AND CLASS 2

Name \_\_\_\_\_

### 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 \_\_\_\_\_ Contact number \_\_\_\_\_

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. \_\_\_\_\_

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.**

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   Convulsions/seizures   Hemophilia

Asthma   Diabetes   High blood pressure

Cancer/leukemia   Heart trouble   Kidney disease

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, or history of, 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 \_\_\_\_\_

Administration Use Only

Pack \_\_\_\_\_

Den \_\_\_\_\_