

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"/>
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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:

