

Date: \_\_\_\_\_  
 Early Bird  
 Confirmation sent

# **WEBELOS RESIDENT CAMP 2017 CAMP Youth REGISTRATION FORM**

## **“Gold Rush”**

**\*\*Please print legibly\*\***

**Each YOUTH and ADULT attending must complete this form. Please use a separate copy for each person.** Application is due with payment and at least 14 days before you arrive at camp. No walk-ins allowed. Fees are transferable but non-refundable. Both parts A & B of the NEW Annual Health and Medical Record (BSA Form #680-001) is REQUIRED for **EACH** participant (be sure that a parent signs each Webelos Scout's form) and are included as part of this application. Return this form to your leader or mail completed form with payment to: *Webelos Resident Camp, Lincoln Heritage Council, 12001 Sycamore Station Place Louisville, KY 40299.*

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Pack #: \_\_\_\_\_ District: \_\_\_\_\_

In fall 2017 will you be

Webelos (4<sup>th</sup> grade) or  Arrow of Light (5<sup>th</sup> grade)

I was a participant last year

**T-shirt Size:**  YS  YM  Adult Small

Adult Med.  Adult Large  Adult XL  Adult 2XL  Adult 3XL

Name of Leader-in-Charge for Pack at Camp: \_\_\_\_\_

### **Camp session preferred:**

Mark each choice with a 1, 2, or 3, in the order you want to go to camp. Once a session is full it will be closed to new registrations.

You must mark at least 3 possible sessions or your application will be considered invalid and returned to you for correction.

Sessions are filled on a first come, first served basis. No exceptions! You will be notified if your 1st choice is closed.

Location Codes: TMR=Tunnel Mill Scout Reservation, RCM=Roy C Manchester

\_\_\_\_\_ Web 1 6/22-6/25 (TMR)

\_\_\_\_\_ Web 2 6/29-7/2 (TMR)

\_\_\_\_\_ Web 3 7/6-7/9 (TMR)

\_\_\_\_\_ Combined 1 7/20-7/23\*\* (RCM)

\*\*Combined Cub and Webelos Session.

**IF YOU ARE PLANNING TO COME AS A PACK, YOU MUST SIGN UP AND PAY TOGETHER TO ENSURE EVERYONE GETS INTO THE SAME SESSION**

### **Camp Fees:** (Make checks payable to Lincoln Heritage Council BSA)

Webelos Resident Camp fee is \$165.00. Early bird registration for youth gets a great discount, only **\$145.00 if paid in full by May 5th.** The adult registration fee is \$70. A late fee of \$10 for youth and adults is charged for each payment not paid in full by June 1. **GREAT DEAL = 1 FREE ADULT WITH EVERY 6 PAID SCOUTS FROM YOUR PACK.**

All applicants PLEASE LIST ANY OTHER INFORMATION THAT WOULD BE IMPORTANT FOR THE STAFF TO KNOW INCLUDING DIETARY OR OTHER SPECIAL NEEDS THAT WOULD HELP THE STAFF PROPERLY PREPARE FOR YOUR PARTICIPATION AT CAMP:

#### **Miner 4/29 Day**

On Saturday, April 29<sup>th</sup>, come meet the Gold Rush Staff for fun, games, lessons, range time, and more. **Event is free with a paid registration** and we will be taking registrations that day.

Yes, we plan to attend.  No, we will not be able to attend

1-6701-022-21-TMR  
1-6701-090-21-RCM

## Part A: Informed Consent, Release Agreement, and Authorization

Full name: \_\_\_\_\_

DOB: \_\_\_\_\_

High-adventure base participants:

Expedition/crew No.: \_\_\_\_\_

or staff position: \_\_\_\_\_

### Informed Consent, Release Agreement, and Authorization

I understand that participation in Scouting activities involves the risk of personal injury, including death, due to the physical, mental, and emotional challenges in the activities offered. Information about those activities may be obtained from the venue, activity coordinators, or your local council. I also understand that participation in these activities is entirely voluntary and requires participants to follow instructions and abide by all applicable rules and the standards of conduct.

In case of an emergency involving me or my child, I understand that efforts will be made to contact the individual listed as the emergency contact person by the medical provider and/or adult leader. 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 protected health information to the adult in charge, camp medical staff, camp management, and/or any physician or health-care provider involved in providing medical care to the participant. Protected Health Information/Confidential Health Information (PHI/CHI) under the Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. §§160.103, 164.501, etc. seq., as amended from time to time, includes 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.

(If applicable) I have carefully considered the risk involved and hereby give my informed consent for my child to participate in all activities offered in the program. I further authorize the sharing of the information on this form with any BSA volunteers or professionals who need to know of medical conditions that may require special consideration in conducting Scouting activities.

With appreciation of the dangers and risks associated with programs and activities, on my own behalf and/or on behalf of my child, I hereby fully and completely release and waive any and all claims for personal injury, death, or loss that may arise against the Boy Scouts of America, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with any program or activity.

I also hereby assign and grant to the local council and the Boy Scouts of America, as well as their authorized representatives, the right and permission to use and publish the photographs/film/videotapes/electronic representations and/or sound recordings made of me or my child at all Scouting activities, and I hereby 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 liability from such use and publication. I further 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 BSA, and I specifically waive any right to any compensation I may have for any of the foregoing.

**NOTE: Due to the nature of programs and activities, the Boy Scouts of America and local councils cannot continually monitor compliance of program participants or any limitations imposed upon them by parents or medical providers. However, so that leaders can be as familiar as possible with any limitations, list any restrictions imposed on a child participant in connection with programs or activities below.**

List participant restrictions, if any:  None

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. If I am participating at Philmont, Philmont Training Center, Northern Tier, Florida Sea Base, or the Summit Bechtel Reserve, I have also read and understand the supplemental risk advisories, including height and weight requirements and restrictions, and understand that the participant will not be allowed to participate in applicable high-adventure programs if those requirements are not met. The participant has permission to engage in all high-adventure activities described, except as specifically noted by me or the health-care provider. If the participant is under the age of 18, a parent or guardian's signature is required.

Participant's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/guardian signature for youth: \_\_\_\_\_ Date: \_\_\_\_\_

(If participant is under the age of 18)

Second parent/guardian signature for youth: \_\_\_\_\_ Date: \_\_\_\_\_

(If required; for example, California)

### Complete this section for youth participants only:

#### Adults Authorized to Take to and From Events:

You must designate at least one adult. Please include a telephone number.

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Telephone: \_\_\_\_\_

Telephone: \_\_\_\_\_

#### Adults NOT Authorized to Take Youth To and From Events:

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Telephone: \_\_\_\_\_

Telephone: \_\_\_\_\_



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## Part B: General Information/Health History

Full name: \_\_\_\_\_

DOB: \_\_\_\_\_

**High-adventure base participants:**

Expedition/crew No.: \_\_\_\_\_

or staff position: \_\_\_\_\_

Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Height (inches): \_\_\_\_\_ Weight (lbs.): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP code: \_\_\_\_\_ Telephone: \_\_\_\_\_

Unit leader: \_\_\_\_\_ Mobile phone: \_\_\_\_\_

Council Name/No.: \_\_\_\_\_ Unit No.: \_\_\_\_\_

Health/Accident Insurance Company: \_\_\_\_\_ Policy No.: \_\_\_\_\_

!

Please attach a photocopy of both sides of the insurance card. If you do not have medical insurance, enter "none" above.

!

**In case of emergency, notify the person below:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Home phone: \_\_\_\_\_ Other phone: \_\_\_\_\_

Alternate contact name: \_\_\_\_\_ Alternate's phone: \_\_\_\_\_

### Health History

Do you currently have or have you ever been treated for any of the following?

Yes	No	Condition	Explain
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	Last HbA1c percentage and date: _____
<input type="checkbox"/>	<input type="checkbox"/>	Hypertension (high blood pressure)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Adult or congenital heart disease/heart attack/chest pain (angina)/heart murmur/coronary artery disease. Any heart surgery or procedure. Explain all "yes" answers.	_____
<input type="checkbox"/>	<input type="checkbox"/>	Family history of heart disease or any sudden heart-related death of a family member before age 50.	_____
<input type="checkbox"/>	<input type="checkbox"/>	Stroke/TIA	_____
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	Last attack date: _____
<input type="checkbox"/>	<input type="checkbox"/>	Lung/respiratory disease	_____
<input type="checkbox"/>	<input type="checkbox"/>	COPD	_____
<input type="checkbox"/>	<input type="checkbox"/>	Ear/eyes/nose/sinus problems	_____
<input type="checkbox"/>	<input type="checkbox"/>	Muscular/skeletal condition/muscle or bone issues	_____
<input type="checkbox"/>	<input type="checkbox"/>	Head injury/concussion	_____
<input type="checkbox"/>	<input type="checkbox"/>	Altitude sickness	_____
<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric/psychological or emotional difficulties	_____
<input type="checkbox"/>	<input type="checkbox"/>	Behavioral/neurological disorders	_____
<input type="checkbox"/>	<input type="checkbox"/>	Blood disorders/sickle cell disease	_____
<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells and dizziness	_____
<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	_____
<input type="checkbox"/>	<input type="checkbox"/>	Seizures	Last seizure date: _____
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal/stomach/digestive problems	_____
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	_____
<input type="checkbox"/>	<input type="checkbox"/>	Excessive fatigue	_____
<input type="checkbox"/>	<input type="checkbox"/>	Obstructive sleep apnea/sleep disorders	CPAP: Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	List all surgeries and hospitalizations	Last surgery date: _____
<input type="checkbox"/>	<input type="checkbox"/>	List any other medical conditions not covered above	_____

## Part B: General Information/Health History

Full name: \_\_\_\_\_  
 DOB: \_\_\_\_\_

High-adventure base participants:  
 Expedition/crew No.: \_\_\_\_\_  
 or staff position: \_\_\_\_\_

### Allergies/Medications

Are you allergic to or do you have any adverse reaction to any of the following?

Yes	No	Allergies or Reactions	Explain	Yes	No	Allergies or Reactions	Explain
<input type="checkbox"/>	<input type="checkbox"/>	Medication		<input type="checkbox"/>	<input type="checkbox"/>	Plants	
<input type="checkbox"/>	<input type="checkbox"/>	Food		<input type="checkbox"/>	<input type="checkbox"/>	Insect bites/stings	

List all medications currently used, including any over-the-counter medications.

CHECK HERE IF NO MEDICATIONS ARE ROUTINELY TAKEN.  IF ADDITIONAL SPACE IS NEEDED, PLEASE INDICATE ON A SEPARATE SHEET AND ATTACH.

Medication	Dose	Frequency	Reason

YES  NO Non-prescription medication administration is authorized with these exceptions: \_\_\_\_\_

Administration of the above medications is approved for youth by:

\_\_\_\_\_  
 Parent/guardian signature MD/DO, NP, or PA signature (if your state requires signature)



**Bring enough medications in sufficient quantities and in the original containers. Make sure that they are NOT expired, including inhalers and EpiPens. You SHOULD NOT STOP taking any maintenance medication unless instructed to do so by your doctor.**



### Immunization

The following immunizations are recommended by the BSA. Tetanus immunization is required and must have been received within the last 10 years. If you had the disease, check the disease column and list the date. If immunized, check yes and provide the year received.

Yes	No	Had Disease	Immunization	Date(s)	Please list any additional information about your medical history:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tetanus		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pertussis		_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diphtheria		_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Measles/mumps/rubella		_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Polio		_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox		_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A		_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B		_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Meningitis		_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Influenza		_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (i.e., Hib)		_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exemption to immunizations (form required)		_____

**DO NOT WRITE IN THIS BOX**  
 Review for camp or special activity

Reviewed by: \_\_\_\_\_  
 Date: \_\_\_\_\_  
 Further approval required:  Yes  No  
 Reason: \_\_\_\_\_  
 Approved by: \_\_\_\_\_  
 Date: \_\_\_\_\_



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