

# **JR. STAFF/ DEN CHIEFS APPLICATION DAY CAMP -PLEASE USE ONE FORM PER PERSON**

**PARENT OR GUARDIAN MUST COMPLETE ALL SECTIONS OF THIS FORM AND HEALTH FORM. ALL FORMS MUST BE RETURNED TO CUBMASTER or CAMP COORDINATOR. PLEASE PRINT IN INK.  
ALL DEN CHEIF PARTICIPANTS MUST BE 14 YEARS OLD AT THE TIME OF DAY CAMP or a First Class Scout.**

TROOP NUMBER \_\_\_\_\_  
SCOUTMASTER NAME \_\_\_\_\_  
LAST NAME OF VOLUNTEER \_\_\_\_\_  
FIRST NAME \_\_\_\_\_ AGE \_\_\_\_\_  
PARENT/GUARDIAN'S NAME \_\_\_\_\_  
HOME ADDRESS \_\_\_\_\_  
CITY / STATE / ZIP \_\_\_\_\_  
PHONE \_\_\_\_\_  
EMAIL \_\_\_\_\_

**ONLY JR STAFF AND DEN CHIEFS ATTENDING ALL FIVE DAYS RECEIVE A FREE TSHIRT. TSHIRT ORDER (CIRCLE CORRECT ADULT SIZE):  
S \_\_\_ M \_\_\_ L \_\_\_ XL \_\_\_ 2XL \_\_\_ 3XL \_\_\_  
(SIZES ARE NOT INTERCHANGEABLE AT CAMP. IF IN DOUBT, ORDER A LARGER SIZE.) YOU WILL BE EXPECTED TO ATTEND AN ORIENTATION/TRAINING. Date & Time TBA.**

**CHECK THE STATION OR AREA YOU WILL BE VOLUNTEERING AT: (we will try to accommodate all requests but cannot guarantee position)**

\_\_\_\_\_ Registration/ Daily Check-In and Check-Out  
\_\_\_\_\_ Den Chief ( Webelos / Bears / Wolf / Tiger ) Please circle one.  
\_\_\_\_\_ Arts & Crafts  
\_\_\_\_\_ Music  
\_\_\_\_\_ Sports and Games  
\_\_\_\_\_ Safety and Weather  
\_\_\_\_\_ Nature  
\_\_\_\_\_ Shooting Sports  
\_\_\_\_\_ Aquatics  
\_\_\_\_\_ Den Skills/ Advancement  
\_\_\_\_\_ Floater (can run errands)

**Days Attending**  
M\_\_\_ T\_\_\_ W\_\_\_ Th\_\_\_ F\_\_\_

**\*\*\*Complete this form and the attached health form. If you have a parent volunteer or cub scout in the same family attending camp, all forms and fees should be submitted together. If no parent will attend, you MUST be 14 years of age and/or a 1<sup>st</sup> Class Scout!**

**Health History** (Please Print)

THE INFORMATION ON THE FOLLOWING PAGES **MUST** BE FILLED OUT AND ON FILE FOR EACH VOLUNTEER ATTENDING CAMP!

**Annual Health and Medical Record**  
**(Valid for 12 calendar months)**

The Boy Scouts of America recommends that all youth and adult members have annual medical evaluations by a certified and licensed health-care provider. In an effort to provide better care to those who may become ill or injured and to provide youth members and adult leaders a better understanding of their own physical capabilities, the Boy Scouts of America has established minimum standards for providing medical information prior to participating in various activities. Those standards are offered below in one three-part medical form. Note that unit leaders must always protect the privacy of unit participants by protecting their medical information.

**Prescriptions**

The taking of prescription medication is the responsibility of the individual taking the medication and/or that individual's parent or guardian. A leader, after obtaining all the necessary information, can agree to accept the responsibility of making sure a youth takes the necessary medication at the appropriate time, but BSA does not mandate or necessarily encourage the leader to do so. Also, if state laws are more limiting, they must be followed.

**Last name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Allergies:** \_\_\_\_\_ **Emergency contact No.:** \_\_\_\_\_

\_\_\_\_\_  
**Physician's Name** \_\_\_\_\_

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

**Height** FT \_\_\_ IN \_\_\_ **WEIGHT** \_\_\_\_\_ **lbs.**

**Annual BSA Health and Medical Record - Part A**

**GENERAL INFORMATION**

Council name/ \_\_\_\_\_ 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  
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: **Allergies or Reaction to:** Medications

\_\_\_\_\_

Food, Plants, or Insect Bites \_\_\_\_\_

**NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

Please mark Yes or No to the following: Have you ever had or been treated for? (if yes, also list last date of treatment)

	YES	NO	Last Treated or Mark Current
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			

**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**

Tetanus \_\_\_\_\_  
 Pertussis \_\_\_\_\_  
 Diptheria \_\_\_\_\_  
 Measles \_\_\_\_\_  
 Mumps \_\_\_\_\_  
 Rubella \_\_\_\_\_  
 Polio \_\_\_\_\_  
 Chicken pox \_\_\_\_\_  
 Hepatitis A \_\_\_\_\_

Hepatitis B \_\_\_\_\_  
 Influenza \_\_\_\_\_

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

Exemption to immunizations claimed \_\_\_\_\_ (please attach form)

**NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**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 Permanent

Medication \_\_\_\_\_  
Strength \_\_\_\_\_ Frequency \_\_\_\_\_  
Reason for medication \_\_\_\_\_

Approximate date started \_\_\_\_\_  
Temporary Permanent

Medication \_\_\_\_\_  
Strength \_\_\_\_\_ Frequency \_\_\_\_\_  
Reason for medication \_\_\_\_\_

Approximate date started \_\_\_\_\_  
Temporary Permanent

Medication \_\_\_\_\_  
Strength \_\_\_\_\_ Frequency \_\_\_\_\_  
Reason for medication \_\_\_\_\_

Approximate date started \_\_\_\_\_  
Temporary Permanent

**NOTE: Be sure to bring medications in the appropriate containers, and make sure that they are NOT expired. It is recommended that all efforts be made to administer morning medications before arrival at camp.**

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

**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 (Please circle one)**  
**Initials of Parent/Guardian)** \_\_\_\_\_

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

Participant's  
Signature

---

Parent/guardian's  
Signature

---

(if under the age of 18)

Date \_\_\_\_\_