

ADULT LEADER/VOLUNTEER REGISTRATION DAY CAMP - PLEASE USE ONE FORM PER PERSON.

**ALL FORMS MUST BE RETURNED TO PACK CAMPING COORDINATOR or CUBMASTER
With Registration Forms. PLEASE PRINT IN INK.**

PACK NUMBER _____
LAST NAME _____ FIRST NAME _____
HOME ADDRESS _____
CITY / STATE / ZIP _____
PHONE (Home) _____ (Cell) _____
EMAIL _____
SON'S NAME, if attending _____

**ONLY DEN LEADERS VOLUNTEERS and STAFF MEMBERS ATTENDING ALL FIVE
DAYS RECEIVE A FREE TSHIRT. TSHIRT ORDER (CIRCLE CORRECT ADULT
SIZE):**

S ___ M ___ L ___ XL ___ 2XL ___ 3XL ___ 4XL ___

**(SIZES ARE NOT INTERCHANGEABLE AT CAMP. IF IN DOUBT, ORDER A LARGER SIZE.) Additional
shirts can be ordered on your son's registration form.**

**The discount for 5-Day Volunteers is ½ off (1) Cub Scout Registration Fee (\$40
instead of \$80)) Please mark \$40.00 on your son's application for fees.**

****YOU WILL BE EXPECTED TO ATTEND A STAFF ORIENTATION TRAINING IF ATTENDING CAMP
MORE THAN ONE DAY**

**CHECK THE STATION OR AREA YOU WILL BE VOLUNTEERING AT: (we will make every
attempt to honor all placement requests)**

- _____ **Registration/ Daily Check-In and Check-Out Staff**
- _____ **Den Leader (Webelos / Bears / Wolf / Tiger) Please circle one.**
- _____ **Den Skills Session Volunteer Staff**
- _____ **Fun and Games Session Volunteer Staff**
- _____ **Arts and Crafts Session Volunteer Staff**
- _____ **Nature Session Volunteer Staff**
- _____ **Fantastic Friday Session Volunteer Staff**
- _____ **Shooting Sports (Tent Area) Session Volunteer Staff**
- _____ **Aquatics Session Volunteer Staff**
- _____ **Be Prepared Session Volunteer Staff**
- _____ **Floater (can run errands) Staff**
- _____ **Den Chief Assignments (guides den chiefs) Staff**
- _____ **Health Officer Assistant (helps in First Aid area)**

DAYS ATTENDING CAMP M ___ T ___ W ___ Th ___ F ___

*****Attach this form to the camp registration form with your completed health form to the
forms for your cub scout (if applicable) You may write one check to cover all fees and
make payable to: Palmetto Council BSA.**

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 Write "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.)

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 _____