

Temescal South Cub Scout Day Camp

June 4th to 8th 4 P.M. to 8 P.M.

Norco LDS Church 3600 Norconian Dr.

\$70

Scout T-Shirt included if registered by 4/23/18

Please return complete packet to your Den Leader as soon as possible.

Camp registration will be CLOSED when capacity is reached

Turn in payment and correctly completed forms to guarantee your spot.

Incomplete paperwork will NOT be considered for registration.

Day Camp Packets MUST include the following

1. Day Camp Registration Form.
2. Part A Medical Form (with both parent signatures for youth)
3. Part B Medical Form (completely filled out)
4. Copy of both sides of insurance cards (initial on registration form if no insurance)

EVERY PERSON attending Day Camp (Scout, Child, or Adult) must have a completed registration packet.

**You may fill these forms out digitally, and then print it with the fields populated.
All signature fields must be signed for the form to be valid.**

You may,

Fill, print, sign, turn in

or

Fill, print, sign, scan, email.

California Inland Empire Council Boy Scouts of America
TEMESCAL SOUTH DAY CAMP INDIVIDUAL REGISTRATION FORM

Pack# _____

Name: _____

PHONE: _____ (HOME) _____ (CELL)

HOME ADDRESS (inc City): _____

DATE OF BIRTH: _____ **AGE:** _____ MALE FEMALE

SCOUT PARENT NAME (if youth application): _____

EMAIL (if adult application): _____

PARENT EMAIL (if youth application): _____

T-Shirt Size (check selection) (sizes not guaranteed):

youthSM youthMED youthLG adultSM adultMED adultLG adultXL adult 2XL adult3XL

Cub Scout (select grade and rank below) -

CUB SCOUT GRADE AS OF SEPTEMBER 2018 (check selection):

1ST 2ND 3RD 4TH 5TH

RANK AS OF SEPTEMBER 2018 (check selection):

TIGER WOLF BEAR WEB Arrow of Light

A registration form, medical forms part A & B, and a copy of both sides of health insurance cards MUST be provided for each Cub Scout.

TIGER SCOUTS MUST HAVE AN ADULT PARTNER.

The undersigned consent that the Council may furnish BB Guns and Bow and Arrow to the above named minor (Cub Scout) for the purpose of instruction and safe handling under strict supervision of knowledgeable instructors.

Parent Signature: _____

Non Scout Children - A program for NON-SCOUT children (ages 3-13) of camp staff members for \$6 per day. The parent of the Non-Scout child must be a volunteer in camp at all times. Children must be potty trained. Due to insurance, non-scout children have a separate program and will not be able to participate in sports, archery and bb gun, and other activities that directors may feel is a concern, nor can they be "helpers" on site. A registration form, medical forms part A & B, and a copy of both sides of health insurance cards MUST be provided for each child. All Non-Scout children will pay an additional \$8 if a t-shirt is desired.

Den Chief - Den Chiefs under 14 years of age will remain with his current pack(s) or under direct supervision of parent/guardian. A registration form, medical forms part A & B, and a copy of both sides of health insurance cards MUST be provided for Den Chief participating at day camp.

Adult Staff (18yr or older) - A registration form and medical forms part A & B MUST be filled out for each volunteer. Youth Protection Completion Date: _____

Tiger Partner (18yr or older) - Must stay with Tiger Scouts at all times. A registration form and medical forms part A & B MUST be filled out for each volunteer. Youth Protection Completion Date: _____

Tiger Scout Name: _____

Days Volunteering (check selection):

Mon Tue Wed Thur All (Mon-Thur, Friday is Family Day)

Volunteers who work Mon-Thur of camp session will receive their t-shirt for free.

Part-time volunteers will pay \$8 per shirt (\$9 for 2x, \$10 for 3x) T-shirt for Non-scout child is optional (\$8).

ALL PARTICIPANTS MUST COMPLETE A BSA ANNUAL HEALTH AND MEDICAL RECORD (Parts A & B).

A copy of both the front and back of their insurance card must be provided for each participant.

Please initial here if the participant DOES NOT have insurance. _____

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: _____



Part B: General Information/Health History

Full name: _____

High-adventure base participants:

Expedition/crew No.: _____

or staff position: _____

DOB: _____

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
		Diabetes	Last HbA1c percentage and date:
		Hypertension (high blood pressure)	
		Adult or congenital heart disease/heart attack/chest pain (angina)/heart murmur/coronary artery disease. Any heart surgery or procedure. Explain all "yes" answers.	
		Family history of heart disease or any sudden heart-related death of a family member before age 50.	
		Stroke/TIA	
		Asthma	Last attack date:
		Lung/respiratory disease	
		COPD	
		Ear/eyes/nose/sinus problems	
		Muscular/skeletal condition/muscle or bone issues	
		Head injury/concussion	
		Altitude sickness	
		Psychiatric/psychological or emotional difficulties	
		Behavioral/neurological disorders	
		Blood disorders/sickle cell disease	
		Fainting spells and dizziness	
		Kidney disease	
		Seizures	Last seizure date:
		Abdominal/stomach/digestive problems	
		Thyroid disease	
		Excessive fatigue	
		Obstructive sleep apnea/sleep disorders	CPAP: Yes <input type="checkbox"/> No <input type="checkbox"/>
		List all surgeries and hospitalizations	Last surgery date:
		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
		Medication				Plants	
		Food				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.

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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:
			Tetanus		
			Pertussis		
			Diphtheria		
			Measles/mumps/rubella		
			Polio		
			Chicken Pox		
			Hepatitis A		
			Hepatitis B		
			Meningitis		
			Influenza		
			Other (i.e., HIB)		
			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: _____