

**CUB ADVENTURE CAMP
ADULT HEALTH FORM & STAFF AGREEMENT
TO SERVE ON CUB ADVENTURE DAY CAMP STAFF**

IN THE FOLLOWING POSITION (Check One) Day Camp Director Program Director First Aid Director
 Crafts Director Field Sports Director Games Director Nature Director Webelos Director Pee Wee Director
 Pack Den Leader Other _____

NAME _____ AGE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

TELEPHONE NUMBERS: HOME () _____ BUS () _____

PACK NUMBER _____ POSITION IN SCOUTING _____ HAVE YOU BEEN TRAINED? _____

LOCATION OF CAMP ATTENDING _____

IN CASE OF EMERGENCY, NOTIFY:

NAME _____ RELATIONSHIP _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME TELEPHONE NUMBER () _____ BUSINESS TELEPHONE NUMBER () _____

HEALTH & ACCIDENT INSURANCE COVERAGE BY (NAME OF COMPANY) & POLICY NUMBER:

GENERAL HEALTH CONDITIONS

DO YOU TIRE EASILY? _____

HAVE YOU EVER HAD SUNSTROKE OR HEAT EXHAUSTION? IF SO, WHICH ONE:

ARE YOU ALLERGIC TO BEE STINGS? IF YES, DO YOU HAVE MEDICATION? IF YES, NAME OF MEDICATION:

ARE YOU ALLERGIC TO ANY OTHER INSECT BITES? IF YES, WHICH ONES:

OTHER ALLERGIES - MEDICINE, FOOD, PETS, ETC.: _____

HAVE YOU EVER HAD MORE THAN A BRIEF MINOR ILLNESS OR INJURY DURING THE PAST YEAR? IF SO, WHAT:

DO YOU HAVE ANY CONDITION REQUIRING REGULAR MEDICATION OR TREATMENT? IF SO, WHAT:

ANY RESTRICTION OF ACTIVITY FOR MEDICAL REASONS? IF SO, PLEASE EXPLAIN:

I HEREBY CONSENT TO THE USE OF MY VOICE AND/OR PHOTOGRAPH IN THE NEWS COVERAGE, MOVIE MAKING,
OR SIMILAR PROJECTS APPROVED BY THE BOY SCOUTS OF AMERICA.

SIGNATURE _____ DATE _____

OVER FOR PEE WEE INFORMATION

CUB ADVENTURE CAMP PEE WEE HEALTH HISTORY

CHILD'S NAME _____ PARENT'S NAME _____

PACK NUMBER _____ LOCATION OF CAMP ATTENDING _____

HAVE OR SUBJECT TO (CHECK IF YES)

FAINTING SPELLS CONVULSIONS HEART TROUBLE DIABETES EYES-EARS-NOSE-THROAT

ASTHMA ALLERGIES TO BEE STINGS OR INSECT BITES

OTHER ALLERGIES (medicine, food, pets, etc.) - please list: _____

IF THERE ARE ANY CONDITIONS OR RESTRICTIONS WE SHOULD KNOW ABOUT FOR YOUR CHILD'S SAFETY,
PLEASE DESCRIBE _____

HAS YOUR CHILD HAD ANY SURGERY RECENTLY (CHECK IF YES)__. IF YES, WHAT TYPE OF SURGERY

DATE OF SURGERY _____ DATE OF LAST TETANUS BOOSTER SHOT _____

ANY CONDITIONS NOW REQUIRING REGULAR MEDICATION _____

NAME(S) OF MEDICATION _____

**IF YOUR CHILD IS NOW TAKING MEDICATION
PLEASE SEE THAT IT IS GIVEN TO THE CAMP DIRECTOR EACH MORNING**

**(NOTE: IF YOUR CHILD HAS BEEN EXPOSED TO ANY CONTAGIOUS DISEASE JUST PRIOR TO
CUB ADVENTURE CAMP - DO NOT BRING HIM/HER)**

I HEREBY CONSENT TO THE USE OF MY CHILD'S VOICE AND/OR PHOTOGRAPH IN THE NEWS COVERAGE,
MOVIE MAKING, OR SIMILAR PROJECTS APPROVED BY THE BOY SCOUTS OF AMERICA.

PARENT SIGNATURE _____ DATE _____

OVER FOR ADULT INFORMATION