

DEN CHIEF REGISTRATION AND HEALTH FORM FOR CUB ADVENTURE CAMP SERVICE

- Routing Procedures:
- 1) Scout fills out form and signs
 - 2) Parent fills out **health form on back** and signs
 - 3) Scoutmaster signs and sends to Day Camp Director

Location of Cub Day Camp _____

Scout's Name _____ Troop # _____

Address _____

City _____ State _____ Zip _____

Telephone Number (____) _____ E-mail Address _____

Age _____ Rank _____

CIRCLE AREA in which you would like to work: Crafts - Field Sports - Games - Nature - Webelos

I agree to follow the Den Chief Pledge and serve as Den Chief for Cub Adventure Camp:

I promise to help Cub Scouts (or Webelos Scouts) to the best of my ability; to encourage, guide, and protect them in all activities; and to show them by my example what a Boy Scout is. I will strive to be prompt and dependable, and to cooperate with the leaders in carrying out the program. I will encourage Cub Scouts to join a Webelos den and Webelos Scouts to become Boy Scouts.

Scout's Signature _____

Parent's Signature _____

Scoutmaster's Signature _____

This form will be returned to your Scoutmaster,
certifying your Den Chief service hours at Cub Adventure Camp

Over

To Be Completed By Cub Adventure Camp Staff

Scout _____ has served _____ days as Den Chief at Cub Adventure Camp in the following areas (please circle):

Administration Dens Crafts Field Sports Games Nature Webelos Other (specify):

DAY CAMP DIRECTOR SIGNATURE _____

DEN CHIEF COORDINATOR SIGNATURE _____

SCOUT'S NAME _____ TROOP # _____

HEALTH HISTORY - DEN CHIEF FOR CUB ADVENTURE CAMP

THIS INFORMATION MUST BE COMPLETED AND ON FILE IN CAMP FOR A BOY TO ATTEND CAMP

HAVE OR SUBJECT TO: (CHECK IF YES)

___ ASTHMA ___ FAINTING SPELLS ___ CONVULSIONS ___ DIABETES ___ HEART TROUBLE

___ EYE-EARS-NOSE-THROAT ___ 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 son's safety, please describe: _____

Has your son 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(S) _____

IF YOUR SON IS NOW TAKING MEDICATION, PLEASE SEE THAT IT IS GIVEN TO THE CAMP DIRECTOR EACH MORNING OF CAMP.

IN CASE OF EMERGENCY, CONTACT:

Name _____ Relationship _____

Telephone No.: Home (____) _____ Business (____) _____ Other (____) _____

Family Physician Name _____ Telephone No. (____) _____

PARENT AUTHORIZATION

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed activities except as noted. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the adult leader in charge to secure medical treatment for my son.

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.

SIGNATURE _____ DATE _____

Parent or Guardian