

# 2009 CUB ADVENTURE CAMP CUB SCOUT APPLICATION AND HEALTH HISTORY FORM

**Must be registered Cub Scout or Tiger Cub Graduate**

Return This Form With Fee To Your Cubmaster At Least 30 Days Before Camp  
Fee for 4-5 day Day Camps is \$50 – Fee for 2-3 day Day Camps is \$45 (see Cub Adventure Camp Schedule)

**There is a \$5 savings if received in council office by May 1, 2009**  
(Fee includes Adventure Camp T-shirt, patch, program supplies, and drink)

There is **No Refund** of Adventure Camp Fee

FOR CAMP USE ONLY

Pack Number \_\_\_\_\_ District \_\_\_\_\_ Location of Camp \_\_\_\_\_

Cub's Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Home Telephone Number (\_\_\_\_\_) \_\_\_\_\_ E-mail Address \_\_\_\_\_

Grade boy will enter in the fall \_\_\_\_\_ Boy's Age \_\_\_\_\_ (at time of camp) Date of Birth \_\_\_\_\_

Rank (book) Cub will be working on at time of camp (circle one) Wolf Bear 1<sup>st</sup> Year Webelos 2<sup>nd</sup> Year Webelos

## **In Case Of Emergency, Notify (please print)**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Telephone No. Home ( ) \_\_\_\_\_ Business ( ) \_\_\_\_\_ Other ( ) \_\_\_\_\_

Family Physician Name \_\_\_\_\_ Telephone No. ( ) \_\_\_\_\_

Name of Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_

**Adult helpers (21 or older) are needed at camp. Packs are required to provide walk-around leaders and staff at camp. Please indicate which session(s) you are able to help.**

Adult Helper Name \_\_\_\_\_ Telephone Number (\_\_\_\_\_) \_\_\_\_\_

I have the following First Aid or medical training \_\_\_\_\_

Days of Week Will Help (circle): Mon Tues Wed Thur Fri Sat Sun

Babysitting may be provided for young children of adults working at camp. The children must be at least 2 years of age (and out of diapers) to participate. Not available at all camps, please check with the Camp Director.

Number & Ages of Pee Wees \_\_\_\_\_

**Health History- On Back Of This Form - Must Be Completed**

**Return This Application To Your Cubmaster**

**Cubmasters: Please Return Application To Council Service Center**

PACK NUMBER \_\_\_\_\_ DISTRICT \_\_\_\_\_ CUB'S NAME \_\_\_\_\_

## CUB ADVENTURE CAMP - CUB SCOUT HEALTH HISTORY

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**

### 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