



Webelos Woods 2009



Program Registration Form

Unit # (Pack #) _____ Webelos 1 _____ Webelos 2 _____

Patrol Name _____

Leader Name _____

Phone Number _____

Early Reg.
Paid by Sept. 18

LATE Reg.
Paid after Sept.18

Number of Scouts # _____ X \$20.00 = _____
(Registration includes a patch and T-shirt - please note size below)

X \$25.00 = _____

Number of Leaders # _____ X \$ 5.00= _____
(Registration includes a patch: shirts must be purchased separately)

X \$ 7.00= _____

Number of Saturday Lunches # _____ X \$ 5.00 = _____
(Please specify the # of hot dogs _____ or hamburgers _____)

X \$ 7.00= _____

Number of Saturday Dinners # _____ X \$ 5.00 = _____

X \$ 7.00= _____

Number of Sunday Breakfasts # _____ X \$ 5.00 = _____

X \$ 7.00= _____

Adult Size(s) _____ S _____ M _____ L _____ XL _____ XXL _____ XXXL

Additional T-shirts _____ X \$8.00 = _____

X \$ 12.00= _____

Additional Patches _____ X \$3.00 = _____

X \$ 5.00= _____

TOTAL \$ _____

TOTAL \$ _____

I Need a Patrol _____

Campfire Skit or Song _____

Scout Skills Training Class Selection

Please label each class with a number 1-12 (with 1 being your first choice). We will do our best to put you in the classes you want the most, but please label all the way through 12 in case that is not possible.

Unit # (Pack #) _____ Patrol Name: _____

Knots _____

Lashings _____

Compass _____

Flag Etiquette _____

First Aid ABC's _____

Fire Building _____

Cast Iron Cooking _____

Outdoor Etiquette _____

Paul Bunyan _____

Wilderness Survival _____

Scout Pace _____

Signaling _____

(PLEASE RETURN WITH YOUR REGISTRATION)



PERSONAL HEALTH AND MEDICAL RECORD

CLASS 1 AND CLASS 2

Class 1 (update annually for all participants). Activity: Day camp, overnight hike, or other programs not exceeding 72 hours, with level of activity similar to that of home or school. Medical care is readily available. Current personal health and medical summary (history) is attested by parents to be accurate. This form is filled out by all participants and is on file for easy reference.

Class 2 (required once every 36 months for all participants under 40 years of age). Activity: Resident camp or any other activity such as backpacking, tour camping, or recreational sports involving events lasting longer than 72 consecutive hours, with level of activity similar to that at home or school. Medical care is readily available.

Note: Some states require an **annual** precamp medical evaluation. Your BSA local council service center can advise you about the requirements for your state.

If your child has had a medical evaluation (**physical examination**) within the last 36 months, a copy of the results of this examination must be attached to the health history for all participants in a camping experience lasting longer than 72 consecutive hours. If a copy is not available, a physical examination (using the Class 2 section of this form) must be scheduled by a *licensed health-care practitioner. This medical evaluation (physical examination) also is required if your child is currently under medical care, takes a prescribed medication, requires a medically prescribed diet, has had an injury or illness during the past 6 months that limited activity for a week or more, has ever lost consciousness during physical activity, or has suffered a concussion from a head injury.

*Examinations conducted by licensed health-care practitioners, other than physicians, will be recognized for BSA purposes in those states where such practitioners may perform physical examinations within their legally prescribed scope of practice.

THIS FORM IS NOT TO BE USED BY ADULTS OVER 40, BY HIGH-ADVENTURE PARTICIPANTS (USE FORM NO. 34412A), OR FOR NATIONAL SCOUT JAMBOREE (USE FORM NSJ-34412-01).

CLASS 1 PERSONAL HEALTH AND MEDICAL HISTORY

(To be filled out annually by all participants)

To be filled out by parent, guardian, or adult participant. Please print in ink.

IDENTIFICATION

Name _____ Date of birth _____ Age _____ Sex _____

Name of parent or guardian _____ Telephone _____

Home address _____ City _____ State _____ Zip _____

Business address _____ City _____ State _____ Zip _____

If person named above is not available in the event of an emergency, notify

Name _____ Relationship _____ Telephone _____

Name _____ Relationship _____ Telephone _____

Name of personal physician _____ Telephone _____

Personal health/accident insurance carrier _____ Policy No. _____

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 _____

Date updated _____ Signature of parent/guardian or adult _____

Date updated _____ Signature of parent/guardian or adult _____

Some hospitals require the parent/guardian signature to be notarized. Check with your BSA local council.

NAME

TROOP

CAMP SITE

NAME

Check all items that apply, **past or present**, to your health history. Explain any "Yes" answers.

ALLERGIES: Food, medicines, insects, plants Yes No Explain: _____

GENERAL INFORMATION:	Yes	No		Yes	No		Yes	No
ADHD (Attention-Deficit								
Hyperactivity Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions/seizures	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>

Explain: _____

Please list ALL medications taken in the 30 days **prior** to arrival at the Scouting activity where this form is to be used: _____

List any medications to be taken at camp: _____

List any physical or behavioral conditions that may affect or limit full participation in swimming, backpacking, hiking long distances, or playing strenuous physical games: _____

List equipment needed such as wheelchair, braces, glasses, contact lenses, etc.: _____

Immunizations: (Give date of last inoculation.)

Tetanus toxoid _____	Measles _____	Polio _____
Diphtheria _____	Mumps _____	_____
Pertussis _____	Rubella _____	_____

CLASS 2 MEDICAL EVALUATION

(Read additional requirements outlined on front of form.)

Name _____ Age _____

NOTE TO LICENSED HEALTH-CARE PRACTITIONERS*: The person being evaluated will be attending one or more weeks of camp that may include sleeping on the ground and participating in strenuous activities such as hiking, boating, and vigorous group games. Please review the health history with the participant for any interim changes. **Explain any "abnormal" evaluations.**

PHYSICAL EXAMINATION (To be filled out by a licensed health-care practitioner*)

Height _____ Weight _____ BP _____ / _____ Pulse _____

VISION: Normal _____ Glasses _____ Contacts _____

HEARING: Normal _____ Abnormal _____ Explain _____

Check box:	N	Abn		N	Abn		N	Abn
Growth development	<input type="checkbox"/>	<input type="checkbox"/>	Teeth	<input type="checkbox"/>	<input type="checkbox"/>	Genitalia	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>	Cardiopulmonary system	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>
HEENT	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Neurobehavioral	<input type="checkbox"/>	<input type="checkbox"/>

Explain: _____

Limitations

Activity restrictions _____

Diet restrictions _____

Signature _____ Date _____

Licensed health-care practitioner*

Address _____ Phone _____

City, State, Zip _____

***Examinations conducted by licensed health-care practitioners, other than physicians, will be recognized for BSA purposes in those states where such practitioners may perform physical examinations within their legally prescribed scope of practice.**

INTERVAL RECORD	SCREENING EXAMINATION	
Date, Time, Place, Etc.	(Findings, diagnoses, treatment, instructions, disposition, etc.)	By
#34414B		
PHOTOCOPYING THIS FORM IS PERMITTED.		



TROOP

CAMP SITE

Put a Face On Scouting

Photo Release Form

Pack | Troop | Post | Crew # _____ City/Town _____

Contact Name: _____ Phone # _____

The following persons, listed below, appearing in photographs having been taken at Boy Scouts of America meeting, events and functions agree to let Webelos Woods and the Catalina Council and their agents use the undersigned's image for the promotion of Scouting. Those listed will receive no compensation for the use of their image. Their signatures represent their consent to this release agreement.

Individual Name	Individual's Signature	Parent's/Guardian's Signature

Date, Time, & Place: _____

Description of Activity _____

Contact Person's Signature: _____ Date: _____