

"NATIONAL TREASURE!"

2009 ILLOWA CUB SCOUT DAY CAMP REGISTRATION

District
Pack No.
Rank
OFFICE USE ONLY

1. Complete ALL information — PLEASE PRINT CLEARLY

Cub's Name: _____ Pack#: _____ Birth Date: _____
Address: _____ City _____ State _____ Zip _____
Grade in Sept. 2009: 1st 2nd 3rd 4th 5th School: _____
Mother's Name: _____ Daytime Phone: _____
Father's Name: _____ Daytime Phone: _____
Email (1) _____ (2) _____
In case parents cannot be reached IN AN EMERGENCY, WHO SHOULD BE NOTIFIED? Should be local in case of a need for pickup.
Name: _____ Relationship: _____ Daytime Phone: _____
Is there anyone who is NOT ALLOWED to pick your child up from camp? (I.E. A custody issue)
Name: _____ Relationship: _____ Daytime Phone: _____
Please initial here if you do NOT wish event pictures of your family to appear in Council publications: _____

2. Scout's Shirt Size: Youth Med Youth Large Adult Sm (Youth XL) Adult Med Adult Large

3. Indicate days you will be a "DEN WALKER" - (An adult who accompanies Scouts during the day.)

Monday Tuesday Wednesday Thursday Friday
3a. Adult's Name _____ Phone No. _____

Tiger Cubs (boys entering 1st grade in the fall) must have a parent or adult partner with them at all times.
Questions? See your District Day Camp materials or call your Day Camp contact listed below or www.illowabsa.org

4. EVERY Scout and adult in camp must complete the "PERSONAL HEALTH & MEDICAL FORM" (attached) Registration forms without the Personal Health & Medical Form WILL NOT BE ACCEPTED.

5. Identify the camp you will attend with an "X" in the appropriate box and note specifics.

Return this form, the Personal Health & Medical History and payment to your **PACK LEADER**.

HOOVER DISTRICT:
Serving Muscatine & nearby areas
 Dates: June 22 -26, 2009
Location: Weed Park, Muscatine
Time: 8:45am-3:30pm
Cost: \$45 if paid by May 22nd
OR \$60 thereafter
Contact: Cherie Linderman at
563-506-3578 or clinderman@teamssi.com
Tigers (1st Grade in Fall)-Friday only-\$5
Turn registration into your Pack leader.

KITTAN DISTRICT:
Serving Scott County
 Dates: June 22 -26, 2009
Location: Scott County Park
Time: 8:30am-4:00pm
Cost: \$45 if paid by May 22nd
OR \$60 until Jun 19, then call:
Contact: Karen Veale at 563-388-6232
kaveale@mchsi.com
Tigers (1st Grade in Fall)-Friday only-\$5
See District page at www.illowabsa.org

MEDICINE LODGE DISTRICT
Serving Monmouth, Macomb & area
 Dates: June 8-12, 2009
Location: Camp Chicagama
Time: 8:30am-3pm M-W; 12-3pm Th;
4-8pm Fri.
Cost: \$40 if paid by May 22nd
OR \$50 thereafter
Contact: Esther Dohrman at 309-255-6848
el-murray@wiu.edu
Be sure to bring a sack lunch!

MESQUAKIE DISTRICT:
Serving Clinton & Jackson Co.
 Dates: June 17-20, 2009
Location: Grace Camp-DeWitt Hwy 61
Time: 8:30am-3pm
Cost: \$45 due by May 22nd
OR \$50 thereafter
Contact: Keith Townsley at 563-659-5167
kmtownsley@iowatelecom.net
Be sure to bring a sack lunch!
See District page at www.illowabsa.org

SAUKENUK DISTRICT:
Serving Rock Island, Henry & Mercer Co.
 Dates: June 15-19, 2009
Location: Blackhawk State Park
Time: 8:30am-3:15pm
Cost: \$45 if paid by May 22nd
OR \$60 thereafter
Contact: Lisa Francis at 309-629-2102
tfrancis@winco.net
See District page at www.illowabsa.org

SHA-BO-NA DISTRICT:
Serving Galesburg & nearby areas
 Dates: July 13-17, 2009
Location: Little John Cons Club
Time: 8:30am-3:30pm
Cost: \$40 paid by May 22nd
OR \$55 thereafter
Contact: Mark Burton at 309-371-7434
elburto2@comcast.net
See District page at:
www.illowabsa.org

6. SIGNATURE OF PARENT or GUARDIAN: _____ 6a. UNIT LEADER INITIALS: _____



CLASS 1 PERSONAL HEALTH AND MEDICAL HISTORY



NAME: _____
PACK/TROOP/CREW NO. _____
CAMP SITE: _____

(To be filled out annually by parent, guardian, or adult for ALL participants.)

Height _____ Weight _____ Eye Color _____ Hair Color _____

IDENTIFICATION: PLEASE PRINT IN INK!

Name _____ Date of birth _____ Age _____ Sex _____

Name of parent or guardian _____ Phone _____

Home address _____ City _____ State _____ Zip _____

Business address _____ City _____ State _____ Zip _____

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

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name of personal physician _____ Phone _____

Personal health/accident insurance carrier _____ Policy No. _____

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, including drug, dosage, route (oral, injection, etc.), and frequency: _____

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 _____
OR DPT _____	OR MMR _____	
Hepatitis A _____	Varicella _____	OR Chicken pox _____
Hepatitis B _____		

Check this box if you do NOT permit the publication of your child's (or your own) photograph or likeness for Scouting purposes.

I give permission for full participation in all 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.) (This authorization is valid for 1 year and may be reauthorized below.)

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.