GOLDEN ARROW DISTRICT CUB SCOUT TWILIGHT CAMP
SIBLING REGISTRATION FORM

Name:	Date of Birth / /	Age	Sex
Street Address	City	Zip (+4) -	
Home Phone	Daytime Phone		
Parent/Guardian Name	Email @ .		

*** Remember to complete the Youth Health Form and submit with this registration form**

A. Sibling must be at least three (3) years of age AND potty trained at the time of camp.

B. The Sibling Camp allows parents to be involved with their Cub Scout at Twilight Camp. Sibling Camp is available **only** to brothers and sisters of Cub Scouts whose parents are **Walking Leaders**, or **Staff Members. IF A LEADER FAILS TO ATTEND CAMP TRAINING, THE SIBLING WILL NOT BE ABLE TO ATTEND SIBLING CAMP.**

C. Camp Dates:

Week 1: June 4 -8, 2007, 5:30 pm – 9:00 pm ☐ Week 2: June 11 – 15, 2007, 5:30 pm – 9:00 pm ☐

D. PERSON AUTHORIZED TO PICK UP CHILD (limit 2)

1.______________________________ 2.______________________________
(name & number) (name & number)

E. T-Shirt Size: Please check appropriate size. This will be your child's camp uniform, and it must be worn **EVERY** night. When ordering your child's t-shirt, keep in mind that the t-shirts do shrink and tend to run small. Additional shirts are $8.00 each.

Youth Medium (10-12) ☐ Adult Small (34-36) ☐ Adult Large (42-44) ☐
Youth Large (14-16) ☐ Adult Medium (38-40) ☐ Extra Shirt (same size, $8.00) ☐

F. Camp Fee for Sibling Camp is $30.00. This fee includes: Camp T-shirt, water bottle, patch and all daily activities. Please make check payable to **BSA. Early Bird Registration – $5.00 discount per Sibling if registration is received by March 31, 2007.**

G. Please **complete this form and a Youth Health Form** and turn both in well before the registration deadline. Registration forms will be accepted at the monthly Roundtables, or by mail to: Twilight Camp Registrar, Joan Englander, 9334 Portal Dr., Houston, TX 77031-221, well before the registration end date of April 30, 2007. SPACE IS LIMITED, SO REGISTER EARLY.

H. Registration Ends on April 30, 2007. Packs must have all forms & fees turned in no later than April 30, 2007. Registration will be accepted on a first come, first served basis, beginning January 1, 2007.

I. NO REFUNDS WILL BE GIVEN.

CONSENT TO PHOTOGRAPH, OR RECORD ELECTRONICALLY *(required)*

As Parent/Guardian of this child, I understand and agree that my child may be photographed and/or videotaped for promotional purposes only. My child's name, or any personal information, will not appear with any video or photographic reproduction. I further understand that the pictures belong to the GAD Twilight Camp, and I will not receive payment, or any other compensation in connection with these pictures.

Signature:______________________________

Questions? Contact:
James Ragan, Twilight Camp Director: Commish_gadtc@yahoo.com, or (281) 499-6811
Diane Ragan, Twilight Program Director: Radiant_gadtc@yahoo.com, or (281) 499-6811
Joan Englander, Twilight Camp Registrar: researcher_gadtc@yahoo.com , or (713) 981-7215

YOUTH HEALTH HISTORY

(please complete the entire form)

Name:__________________________________ Age: __________

Physician:________________________________ Number:__________

In case of an emergency, call these people in this order.

1. _________________________ Phone No._______________ Relation _______________

2. _________________________ Phone No._______________ Relation _______________

3. _________________________ Phone No._______________ Relation _______________

Problems with (check any that apply):

☐ Asthma ☐ Fainting spells ☐ Convulsions ☐ Heart trouble ☐ Diabetes ☐ Seizures

☐ Bleeding Disorders ☐ Allergy to any medication, food, plants, animals, or insect toxins

☐ Any condition that may require special care, medication, or diet

If you checked yes to any of the above, please explain: ______________________________

Have difficulty with (check any that apply): ☐ Eyes, ear, nose, or throat ☐ Digestion ☐ Lungs

Any restrictions of activity for medical reasons? ☐ Yes ☐ No

If yes, please explain: ____

Immunizations: PLEASE NOTE: The Texas Department of Health requires an actual DATE be recorded in the spaces below. ("Current", will no longer be accepted)

	Date of last inoculation		Date of last inoculation		Date of last inoculation
Diphtheria	__________	Measles	__________	Polio	__________
Pertussis	__________	Mumps	__________	Hib	__________
Tetanus	__________	Rubella	__________	Hepatitis B	__________

Allergy or reaction to any of the follow:

Medication: ☐ Yes ☐ No Explain:____________________
Bee stings, insect bites, or plants: ☐ Yes ☐ No Explain:____________________
Food: ☐ Yes ☐ No Explain:____________________
Other: ☐ Yes ☐ No Explain:____________________

Any condition requiring medication? ☐ Yes ☐ No
Name of Medication(s): ____
Will it be necessary to administer this medication while at Twilight Camp? ☐ Yes ☐ No
If yes, please explain:____

Is your child on, or has he recently been on the medication Ritalin, or other medications for ADD or ADHD? ☐ Yes ☐ No
Is he taking a summer break from this medication? ☐ Yes ☐ No

CONSENT TO TREAT(required)

The health history above is correct so far as I know, and the person herein described has permission to engage in all prescribed activities, except as noted by me. In the event the above names cannot be reached in an emergency, I hereby give permission to the physician selected by the Twilight Camp Director to secure proper treatment, including, but not limited to hospitalization, anesthesia, surgery, or injections of medication for my child.

Signature:___________________________________ Date:_______________ Relation:_______________