# GOLDEN ARROW DISTRICT CUB SCOUT TWILIGHT CAMP
# WALKING LEADER REGISTRATION FORM

| Name: | | |
|---|---|---|
| Street Address | City | Zip (+4) - |
| Home Phone | Daytime Phone | Cell Number |
| Parent/Guardian Name | Email @ . | |
| Pack How many years have helped at Twilight Camp? | | |

A. Are you a Registered Scouter? Yes ☐ No ☐

If so, please provide a copy of your BSA Registration with this form

**IN ORDER TO BE IN COMPLIANCE WITH THE TEXAS YOUTH CAMP SAFETY ACT, ALL ADULT VOLUNTEERS WILL BE SUBJECT TO A CRIMINAL BACKGROUND CHECK. Please complete a BSA LEADER APPLICATION before training on May 12th, 2007.**

B. TRAINING: Please provide a copy of any, or all of the following current certifications:

1. Red Cross Certification Yes ☐ No ☐
2. CPR Certifications Yes ☐ No ☐
3. Registered Nurse Yes ☐ No ☐
4. Youth Protection Yes ☐ No ☐

C. Camp Dates: **Leaders must be in attendance ALL DAY, EVERYDAY.**

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

**NOTE: ONE FULL TIME ADULT LEADER IS REQUIRED FOR EVERY FOUR SCOUTS**

D. T-Shirt Size: Please check appropriate size. This will be your camp uniform, and it must be worn **EVERY** night. When ordering your t-shirt, keep in mind that the t-shirts do shrink and tend to run small. Additional shirts are $10.00 each, same size.

Adult Small (34-36) ☐ Adult Large (42-44) ☐ Adult XX Large ☐ Adult XXX Large ☐

Adult Medium (38-40) ☐ Adult X-Large ☐ Extra Shirt (same size, $10.00) ☐

E. All Dens will be formed by the Camp Registration Staff. Volunteers will be placed where needed. That may not necessarily be with the scouts that you volunteered with. However, whenever possible, the staff will try to honor the request. Please list the **ONE** scout with whom you would like to be placed with and rank: Cub **or** Webelos

____________________________________________________________

F. Please complete this form, BSA Class1 Personal Health Form, YTP Training with test score and certificate, and Sex Offender Database Check (instructions are included in the letter to volunteers) and submit the completed registration package 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 77031-2211, well before the registration end date of April 30, 2007. SPACE IS LIMITED, SO REGISTER EARLY.

G. 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.

H. NO REFUNDS WILL BE GIVEN.

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

As a Volunteer, I understand and agree that I may be photographed and/or videotaped for promotional purposes only. My 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

# 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).**

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### 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 ______________ CAMPSITE ______________

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 | ☐ | ☐ | Convulsions/seizures | ☐ | ☐ | Hemophilia | ☐ | ☐ |
| Asthma | ☐ | ☐ | Diabetes | ☐ | ☐ | High blood pressure | ☐ | ☐ |
| Cancer/leukemia | ☐ | ☐ | Heart trouble | ☐ | ☐ | Kidney disease | ☐ | ☐ |

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 | ☐ | ☐ | Teeth | ☐ | ☐ | Genitalia | ☐ | ☐ |
| Skin | ☐ | ☐ | Cardiopulmonary system | ☐ | ☐ | Musculoskeletal | ☐ | ☐ |
| HEENT | ☐ | ☐ | Hernia | ☐ | ☐ | Neurobehavioral | ☐ | ☐ |

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.

34414B
2004 Printing

NAME __________ TROOP __________ CAMPSITE __________