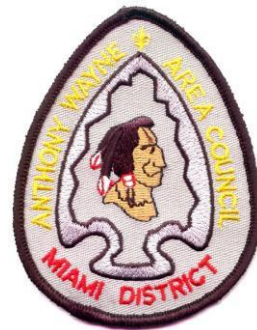


**INDIVIDUAL SCOUT REGISTRATION FOR
MIAMI DISTRICT DAY CAMP
JUNE 10 – 14, 2019
9 AM – 4 PM
STILLWATER RETREAT
10001 YODER RD., YODER, IN**



Name: _____ Pack# _____ Grade completed this June, 2019 _____
(Print only)

TIGER CUBS (1ST Grades in Fall 2019) MUST have an adult

Age: _____

Partner with them at Camp AND fill out a Staff Registration Form

Address: _____ City: _____ Zip: _____

Family e-mail address: _____

Is this a first-year or returning camper who needs a wooden nametag? Yes or No? _____

If so, name to put on tag? _____

In case of emergency, parent/guardian can be reached at this phone number: _____

Please "like" Facebook pages "Miami District Daycamp" and "Miami District AWAC" for daycamp info.

CAMP FEES

Registration Fee: \$ 99.00 = \$ _____

If paid after May 1: \$125.00 = \$ _____

And

Subtract \$5.00 from each brother(s) application

Siblings _____ at \$ -5.00 = \$ _____

Tues. Bear Overnight \$ 12.00 = \$ _____

Wed. Webelos O'night \$ 12.00 = \$ _____

Above fees include one t-shirt and camp patch.

Extra T- Shirts \$10 each = \$ _____

2xl and up \$13 each = \$ _____

TOTAL PAYMENT = \$ _____

Make Checks Payable to: AWAC

Print Scout's name on check on the memo line.

**Mail Application with check to:
Anthony Wayne Area Council 8315
W Jefferson Blvd
Fort Wayne, IN 46804**

Free T-shirt order form

and any additional shirts for campers and parents

Staff shirts are on another form.

Size	Quantity
Youth Med. (10-12)	_____
Youth large (14-16)	_____
Adult Small	_____
Adult Med.	_____
Adult Large	_____
Adult XL	_____
Adult 2XL	_____
Adult 3XL	_____
Adult 4XL	_____

2XL and larger shirt are \$13 each

- Lunch included for all campers and staff.
- Questions? Contact Dawn Mault at 260-710-2653 or email dawnmault@comcast.net.
- The earlier you register and pay, the more snack credits you receive: Jan.=10, Feb.=8, March=6, April=4.

Miami District Website - <http://www.awac.org/Miami>

SIGN CAMPER RELEASE AUTHORIZATION ON PAGE 3.

ATTACH PARTS A & B OF BSA ANNUAL HEALTH AND MEDICAL RECORD



Miami District Day Camp Dietary Restrictions

Miami Day Camp tries to accommodate special dietary needs of Scouts and Scouters. Certain specialized needs will require parental or leadership support to ensure that dietary needs can be adequately met.

Scout/Scouter Name _____ Date of Birth _____ Session _____

Any food allergies (including milk protein allergy)? ____ Yes ____ No. If yes, please explain, list each allergy, including type/severity of reaction:

Is cross-contamination with small amounts of potentially allergy-producing food items a concern?

____ Yes ____ No

Is an Epi-pen required for any of these food allergies? ____ Yes ____ No. If yes, which ones?

Aside from food allergies, are there any other dietary restrictions? If yes, please list:

Does Scout or Scouter have a specific medically-prescribed diet? If yes, please list:

Does Scout or Scouter have any physical disabilities and/or conditions that make eating and/or drinking difficult? If yes, please explain below, including accommodations that need to be made while your child is at camp:

Are there any other special considerations or insights we should know about the Scout's or Scouter's dietary restrictions/concerns? If so, please explain:



Part A: Informed Consent, Release Agreement, and Authorization

A

Full name: _____
DOB: _____

High-adventure base participants:
Expedition/crew No.: _____
or staff position: _____

Informed Consent, Release Agreement, and Authorization

I understand that participation in Scouting activities involves the risk of personal injury, including death, due to the physical, mental, and emotional challenges in the activities offered. Information about those activities may be obtained from the venue, activity coordinators, or your local council. I also understand that participation in these activities is entirely voluntary and requires participants to follow instructions and abide by all applicable rules and the standards of conduct.

In case of an emergency involving me or my child, I understand that efforts will be made to contact the individual listed as the emergency contact person by the medical provider and/or adult leader. In the event that this person cannot be reached, permission is hereby given to the medical provider selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for me or my child. Medical providers are authorized to disclose protected health information to the adult in charge, camp medical staff, camp management, and/or any physician or health-care provider involved in providing medical care to the participant. Protected Health Information/Confidential Health Information (PHI/CHI) under the Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. §§160.103, 164.501, etc. seq., as amended from time to time, includes examination findings, test results, and treatment provided for purposes of medical evaluation of the participant, follow-up and communication with the participant's parents or guardian, and/or determination of the participant's ability to continue in the program activities.

(If applicable) I have carefully considered the risk involved and hereby give my informed consent for my child to participate in all activities offered in the program. I further authorize the sharing of the information on this form with any BSA volunteers or professionals who need to know of medical conditions that may require special consideration in conducting Scouting activities.

With appreciation of the dangers and risks associated with programs and activities, on my own behalf and/or on behalf of my child, I hereby fully and completely release and waive any and all claims for personal injury, death, or loss that may arise against the Boy Scouts of America, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with any program or activity.

I also hereby assign and grant to the local council and the Boy Scouts of America, as well as their authorized representatives, the right and permission to use and publish the photographs/film/videotapes/electronic representations and/or sound recordings made of me or my child at all Scouting activities, and I hereby release the Boy Scouts of America, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with the activity from any and all liability from such use and publication. I further authorize the reproduction, sale, copyright, exhibit, broadcast, electronic storage, and/or distribution of said photographs/film/videotapes/electronic representations and/or sound recordings without limitation at the discretion of the BSA, and I specifically waive any right to any compensation I may have for any of the foregoing.



NOTE: Due to the nature of programs and activities, the Boy Scouts of America and local councils cannot continually monitor compliance of program participants or any limitations imposed upon them by parents or medical providers. However, so that leaders can be as familiar as possible with any limitations, list any restrictions imposed on a child participant in connection with programs or activities below.



List participant restrictions, if any: ☐ None

I understand that, if any information I/we have provided is found to be inaccurate, it may limit and/or eliminate the opportunity for participation in any event or activity. If I am participating at Philmont, Philmont Training Center, Northern Tier, Florida Sea Base, or the Summit Bechtel Reserve, I have also read and understand the supplemental risk advisories, including height and weight requirements and restrictions, and understand that the participant will not be allowed to participate in applicable high-adventure programs if those requirements are not met. The participant has permission to engage in all high-adventure activities described, except as specifically noted by me or the health-care provider. If the participant is under the age of 18, a parent or guardian's signature is required.

Participant's signature: _____ Date: _____

Parent/guardian signature for youth: _____ Date: _____

(If participant is under the age of 18)

Second parent/guardian signature for youth: _____ Date: _____

(If required; for example, California)

Complete this section for youth participants only:

Adults Authorized to Take to and From Events:

You must designate at least one adult. Please include a telephone number.

Name: _____

Name: _____

Telephone: _____

Telephone: _____

Adults NOT Authorized to Take Youth To and From Events:

Name: _____

Name: _____

Telephone: _____

Telephone: _____



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Part B: General Information/Health History

B

Full name: _____

DOB: _____

High-adventure base participants:

Expedition/crew No.: _____

or staff position: _____

Age: _____ Gender: _____ Height (inches): _____ Weight (lbs.): _____

Address: _____

City: _____ State: _____ ZIP code: _____ Telephone: _____

Unit leader: _____ Mobile phone: _____

Council Name/No.: _____ Unit No.: _____

Health/Accident Insurance Company: _____ Policy No.: _____



Please attach a photocopy of both sides of the insurance card. If you do not have medical insurance, enter "none" above.



In case of emergency, notify the person below:

Name: _____ Relationship: _____

Address: _____ Home phone: _____ Other phone: _____

Alternate contact name: _____ Alternate's phone: _____

Health History

Do you currently have or have you ever been treated for any of the following?

Yes	No	Condition	Explain
		Diabetes	Last HbA1c percentage and date:
		Hypertension (high blood pressure)	
		Adult or congenital heart disease/heart attack/chest pain (angina)/heart murmur/coronary artery disease. Any heart surgery or procedure. Explain all "yes" answers.	
		Family history of heart disease or any sudden heart-related death of a family member before age 50.	
		Stroke/TIA	
		Asthma	Last attack date:
		Lung/respiratory disease	
		COPD	
		Ear/eyes/nose/sinus problems	
		Muscular/skeletal condition/muscle or bone issues	
		Head injury/concussion	
		Altitude sickness	
		Psychiatric/psychological or emotional difficulties	
		Behavioral/neurological disorders	
		Blood disorders/sickle cell disease	
		Fainting spells and dizziness	
		Kidney disease	
		Seizures	Last seizure date:
		Abdominal/stomach/digestive problems	
		Thyroid disease	
		Excessive fatigue	
		Obstructive sleep apnea/sleep disorders	CPAP: Yes ☐ No ☐
		List all surgeries and hospitalizations	Last surgery date:
		List any other medical conditions not covered above	



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Part B: General Information/Health History

B

Full name: _____

DOB: _____

High-adventure base participants:

Expedition/crew No.: _____

or staff position: _____

Allergies/Medications

Are you allergic to or do you have any adverse reaction to any of the following?

Yes	No	Allergies or Reactions	Explain	Yes	No	Allergies or Reactions	Explain
		Medication				Plants	
		Food				Insect bites/stings	

List all medications currently used, including any over-the-counter medications.

☐ CHECK HERE IF NO MEDICATIONS ARE ROUTINELY TAKEN.

☐ IF ADDITIONAL SPACE IS NEEDED, PLEASE INDICATE ON A SEPARATE SHEET AND ATTACH.

Medication	Dose	Frequency	Reason

☐ YES ☐ NO Non-prescription medication administration is authorized with these exceptions: _____

Administration of the above medications is approved for youth by: _____

Parent/guardian signature

MD/DO, NP, or PA signature (if your state requires signature)



Bring enough medications in sufficient quantities and in the original containers. Make sure that they are NOT expired, including inhalers and EpiPens. You SHOULD NOT STOP taking any maintenance medication unless instructed to do so by your doctor.



Immunization

The following immunizations are recommended by the BSA. Tetanus immunization is required and must have been received within the last 10 years. If you had the disease, check the disease column and list the date. If immunized, check yes and provide the year received.

Yes	No	Had Disease	Immunization	Date(s)
			Tetanus	
			Pertussis	
			Diphtheria	
			Measles/mumps/rubella	
			Polio	
			Chicken Pox	
			Hepatitis A	
			Hepatitis B	
			Meningitis	
			Influenza	
			Other (i.e., HIB)	
			Exemption to immunizations (form required)	

Please list any additional information about your medical history:

DO NOT WRITE IN THIS BOX

Review for camp or special activity.

Reviewed by: _____

Date: _____

Further approval required: ☐ Yes ☐ No

Reason: _____

Approved by: _____

Date: _____



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