

BLACK SWAMP AREA COUNCIL
GREAT OAKS DISTRICT
2008

Day LEADER Day CAMP REGISTRATION FORM

NAME _____ PACK# _____ BIRTH DATE ___/___/___
ADDRESS _____ CITY _____ ZIP _____
HOME PHONE _____ E-MAIL _____
WORK PHONE _____
CELL PHONE _____

T-SHIRT SIZE (CIRCLE): ADULT SMALL ADULT MEDIUM ADULT LARGE ADULT XL ADULT
2XL ADULT 3XL

I AM AVAILABLE TO ATTEND ___TUESDAY, ___WEDNESDAY, ___THURSDAY (CHECK DAYS YOU
WILL ATTEND)

I AM A TIGER CUB ADULT _____ (CHECK IF YES) MY TIGER CUB IS
_____ (CHILD'S FULL NAME)

ARE YOU CERTIFIED IN CPR? YES/NO ARE YOU CERTIFIED IN FIRST AID? YES/NO
REGISTRATION FEE \$5 FOR ALL DAY LEADERS AND TIGER CUB ADULTS, PAID CHECK _____ OR
CASH _____

DAY LEADERS ARE REQUIRED TO ATTEND A TRAINING SESSION PRIOR TO CAMP. DATES
WILL BE ANNOUNCED.

HEALTH AND MEDICAL HISTORY

CHECK ANY MEDICAL CONDITIONS YOU HAVE:

___ASTHMA ___FAINING SPELLS ___CONVULSIONS ___ALLERGY TO ANY FOOD,
MEDICATION, PLANT, ANIMAL, OR INSECT STING
___BLEEDING DISORDER ___DIABETES ___HEART TROUBLE ___OTHER

EXPLAIN: _____

MEDICATIONS TAKEN DAILY WE SHOULD BE AWARE
OF _____

MEDICAL INSURANCE CARRIER _____ GROUP OR POLICY NUMBER _____

IN CASE OF EMERGENCY NOTIFY:

NAME _____ RELATIONSHIP: _____
HOME PHONE _____ WORK PHONE _____ CELL
PHONE _____
FAMILY DOCTOR _____ PHONE _____

AUTHORIZATION:

I HEREBY GIVE MY PERMISSION TO THE PHYSICIAN SELECTED BY THE ADULT LEADER IN CHARGE TO SECURE PROPER TREATMENT INCLUDING HOSPITALIZATION, ANESTHESIA, OR INJECTION OF MEDICATIONS FOR MYSELF.

SIGNATURE _____ DATE _____

THIS FORM MUST BE TURNED IN ALONG WITH ALL DAY CAMP FEES.