

Suwannee River Area Council

Cub Scout Day Camp 2019

SRAC CSDC @ Maclay Gardens (Tallahassee)
 JUNE 3 - 7, 2019 from 9am – 4pm

Cub Scout Registration Form

Pack# _____

First Name _____ Last Name _____ Home Phone () _____

➔ **Scout Rank In FALL 2019** Tot Tiger Wolf Bear Webelos Arrow of Light / Grade in Fall 2019 _____ Birth Date _____

Mother's Name _____ Daytime Phone () _____

Father's Name _____ Daytime Phone () _____

Address _____

City, Zip _____

BEST E-Mail _____

In case Parents or Guardians cannot be reached, In an emergency who else should be notified? This must be a local person who can pick up the camper if needed.

Name _____ Relationship _____ Daytime Phone () _____

Name _____ Relationship _____ Daytime Phone () _____

Please list who can pick up your child from day camp (legal names): _____

BSA Camp Standards state that there MUST be a 1:4 Adult to Camper ratio every day.

This requires that each Pack provide appropriate coverage for their campers each session each day. It is important that parents volunteer so the 1:4 ratio can be maintained on den and camp levels. **Each adult must complete a separate adult registration form.**

Days the child's parents are volunteering. M T W R F Adult Volunteer name: _____

Camp Fees and Discounts

Send completed registration forms and payment to:

Suwannee River Area Council; 2032 Thomasville Rd.; Tallahassee FL 32308

OR e-mail: Billy.Hartsfield@scouting.org

Cub Scout TOT Lot

Early Bird Registration (through 3 May)..... \$110..... \$55

Regular Registration (5/4 – 5/10) \$125..... \$65

Late Registration (5/11 -5/17 **NO REG. AFRTER 5/17**) \$150..... \$85

Day Camp with 5-day Volunteer for a single Scout..... \$ 80

Day Camp with 5-day Den Leader for a single Scout..... \$ 55

Camp Fee \$ _____

Extra T-Shirts () x \$10 each..... \$ _____

Total \$ _____

One Camper T-Shirt is provided.

Extra shirts cost \$10.00 each:

YS AM

YM AL

YL AXL

AS A2XL

Refund Policy:

Written refund requests must be received by the Council ten days prior to the beginning of camp. A service charge of 25% of the full activity fee will be assessed for all refunds. **Initial:** _____

Talent Release Form: I hereby assign and grant to the Boy Scouts of America 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 Day Camp by the Boy Scouts of America, and I hereby release the Boy Scouts of America from any and all liability from such use and publication. **Initial:** _____

BSA Health & Medical Record Part A for the person named above. To be filled out by parent or guardian annually for all participants.

Check all items that apply, past or present, to your health history, Explain any "Yes" Answers.

Health/Accident Ins. Carrier _____ Policy # _____

Name of Personal Physician _____ Telephone _____

Medical History – Are you now or have you ever been treated for any of the following: Allergies or Reaction to: Medication _____

Asthma Bleeding disorders Food, Plants, or Insect Bites _____

Diabetes Fainting spells Medications: List all medications Including Inhalers and EpiPens

Hypertension (High Blood Pressure) Thyroid disease Medication _____ Strength _____ Frequency _____

Heart Disease (i.e. CHF, CAD, MI) Kidney disease Date Started _____ Reason _____ Temp. Perm.

Stroke/TIA Sickle cell disease Distribution approved by: _____

COPD Seizures Immunizations: If had disease, put "D" and year

Ear/sinus problems Sleep disorders (i.e. sleep apnea) Tetanus _____ Mumps _____ Hepatitis A _____

Muscular / skeletal conditions GI problems (i.e. abdominal, digestive) Pertussis _____ Rubella _____ Hepatitis B _____

Menstrual problems Surgery Diphtheria _____ Polio _____ Influenza _____

Psychiatric/psychological and emotional difficulties Serious Injury Measles _____ Chicken Pox _____ Other(i.e. HIB) _____

Learning disorders (i.e. ADHD, ADD) Other _____ Exception to Immunizations claimed

I give my 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 an adult, my spouse or next of kin). In the event I cannot be reached, I hereby give my permission for 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 me if an adult).

Date: _____ Signature of Adult / Parent / Guardian: _____