

# Tomahawk District – Cub Scout Day Camp Registration 2006

(EACH BOY MUST FILL OUT A SEPARATE FORM)

June 20-23 (2:30 P.M. to 8:30 P.M.) - Fort Bend County Fairgrounds

Camp Fee is \$50.00 per boy  
Please return form to your pack representative, Cubmaster or Committee Chair for turn in.

**“NO REFUNDS” (Money can be transferred to another scout before May 1, 2006)**

**CUB SCOUT INFORMATION:**

e-mail: \_\_\_\_\_

Name \_\_\_\_\_ Pack # \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Parent or Guardian \_\_\_\_\_

What rank and grade will you be when school starts in August, 2006? \_\_\_\_\_  
(Rank) (Grade)

Number of years at Day Camp, including 2006? \_\_\_\_\_

The Cub Scout who is identified on this page may be released to the following person(s) only:

Name	Relationship	Phone

**PLEASE NOTE: The Day Camp Cub Administrative Director must be notified in advance of any change in arrival or departure of the Scout or any change in transportation arrangements.**

Each camper will be provided with a T-shirt that **MUST** be worn each day. Please indicate size:  
 Youth Large (14-16)     Adult Small (34-36)     Adult Medium (38-40)   
 Adult Large (42-44)     Adult Xlarge (46-48)

I, \_\_\_\_\_, by payment of the required fee, give my permission for \_\_\_\_\_ to attend Tomahawk District Day Camp. I certify that the health information submitted is correct to the best of my knowledge. I understand all dens will be formed by the Camp Registration Staff and will not necessarily consist only of the boys from our pack. I hereby assign and grant to the Boy Scouts of America the right and permission to use and publish the photographs/film/video/electronic representations and/or recordings made of myself and/or my child this date 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. I further authorize the reproduction, sale copyright, exhibit, broadcast, electronic storage and/or sound recordings without limitation at the discretion of the Boy Scouts of America and I specifically waive any right to any compensation I may have for any of the foregoing. Names and/or individualized identification shall be unintentional.”

Signed (Parent or Guardian): \_\_\_\_\_ Date: \_\_\_\_\_

**See back for Youth Health History**

# YOUTH HEALTH HISTORY

(please complete entire form)

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

In case of an emergency call these people in this order:

1. \_\_\_\_\_ Phone \_\_\_\_\_ Relation \_\_\_\_\_  
2. \_\_\_\_\_ Phone \_\_\_\_\_ Relation \_\_\_\_\_  
3. \_\_\_\_\_ Phone \_\_\_\_\_ Relation \_\_\_\_\_

Problems with (**check if yes**):

- Asthma       Fainting spells       Convulsions       Heart Trouble  
 Diabetes       Seizures       Bleeding Disorders  
 Allergy to medication, food, plant, animal, or insect  
 Any condition that may require special care, toxin, medication, diet

If you **checked** any of the above, please explain: \_\_\_\_\_

Have difficulty with (**check if yes**):  Eyes, ears, nose, throat       Digestion       Lungs

Any restrictions of activities for medical reasons?  Yes  No

If **Yes**, Explain: \_\_\_\_\_

**Immunizations: PLEASE NOTE: The Texas Department of Health requires an actual DATE be recorded in the spaces below! ("Current" will not be accepted)**

	Date of last Inoculation		Date of last Inoculation		Date of last Inoculation
Tetanus Toxoid	_____	Measles	_____	Polio	_____
Diphtheria	_____	Mumps	_____	Hepatitis B	_____
Pertussis	_____	Rubella	_____		

May Camp Staff apply **Mosquito Repellent**?  Yes  No **Sunscreen/Sun block**  Yes  No

Is your child allergic to any Repellent or Sunscreen/Sun block?  Yes  No

If **YES**, will you provide your own for the child in a marked bottle?  Yes  No

**Allergy or reaction to:**

Medication:  Yes  No      If **Yes** explain: \_\_\_\_\_

Bee stings, insect bites or plants:  Yes  No      If **Yes** explain: \_\_\_\_\_

Food:  Yes  No      If **Yes** explain: \_\_\_\_\_

Other:  Yes  No      If **Yes** explain: \_\_\_\_\_

Any condition requiring medication?  Yes  No

If **Yes**, Name of Medication: \_\_\_\_\_

Will it be necessary to administer this medication while at camp?  Yes  No

If **Yes**, Explain: \_\_\_\_\_

Is your child on or has he recently been on the medication Ritalin, or other medication for ADHD?  Yes  No

Is he taking a summer break from this medication?  Yes  No

**All medication must be given to the first aid personnel upon arrival at camp and must be in original container. Dispensing medication requires medical authorization form.**

## CONSENT TO TREAT

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 Day Camp Director to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_