



Michigamea Lodge 110-Order of the Arrow-Boy Scouts of America

# Adventure Day



“ You were selected as pacesetters in Cheerful Service ”

Arrow-Order of the Arrow

CALLING ALL LODGE MEMBERS: WE NEED YOUR HELP. PART OF THE NEW STRATEGIC PLAN FOR THE ORDER OF THE ARROW WILL BE TO HELP PROMOTE AND SUPPORT CUB SCOUTING. TO THAT END THE LODGE WILL BE SUPPORTING CALUMET COUNCIL'S CUB SCOUT PROGRAM BY RUNNING THE CONCESSION STAND FOR ADVENTURE DAY SATURDAY OCTOBER, 18, 2008.

**LOCATION:** MUNSTER COMMUNITY PARK (BEHIND THE SCOUT SERVICE CENTER)

**TIME:** 7:00 A.M. TO 3:00 P.M.

**COST:** CHEERFUL SERVICE

WE WILL NEED YOUR TIME AND TALENTS TO SERVE THE CUB SCOUTS AND THEIR FAMILIES ON SATURDAY. CUB SCOUTS OUR FUTURE.

**REGISTRATION INFORMATION: ADVENTURE DAY:** NOTE: ON LINE REGISTRATION IS AVAILABLE AT [WWW.OA110.ORG](http://WWW.OA110.ORG)

PLEASE PRINT CLEARLY.

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: \_\_\_\_\_ UNIT: \_\_\_\_\_ DISTRICT: \_\_\_\_\_

EMAIL: \_\_\_\_\_

MEMBERSHIP HONOR (DATES IF APPLICABLE)

ORDEAL: \_\_\_\_\_ BROTHERHOOD: \_\_\_\_\_ VIGIL: \_\_\_\_\_

(CIRCLE ONE) YOUTH OR ADULT

PREFERED TIME TO WORK: (CIRCLE) 7-11 9-1 11-3

CAN YOU WORK THE WHOLE DAY? (CIRCLE) YES OR NO

PLEASE REGISTER FOR ADVENTURE BY FRIDAY OCTOBER 10, 2008 SO WE CAN MAKE THE WORK SCHEDULE

**Personal Health and Medical History Form:**

Each participant must complete the enclosed *Personal Health and Medical History Form*. The form must be submitted at registration. Please note, the form **does not require a doctor's examination or signature**.

This form is required for all participants and must be submitted at the time of Registration.  
**Please note: No Doctor's Examination or Signature is required.**



**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 \_\_\_\_\_

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

**ALLERGIES:** Food, medicines, insects, plants Yes  No  Explain: \_\_\_\_\_

| <b>GENERAL INFORMATION:</b> | Yes                      | No                       | Yes                  | No                       | Yes                      | No                  |                          |                          |
|-----------------------------|--------------------------|--------------------------|----------------------|--------------------------|--------------------------|---------------------|--------------------------|--------------------------|
| ADHD (Attention-Deficit)    |                          |                          |                      |                          |                          |                     |                          |                          |
| Hyperactivity Disorder      | <input type="checkbox"/> | <input type="checkbox"/> | Convulsions/seizures | <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia          | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma                      | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes             | <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer/leukemia             | <input type="checkbox"/> | <input type="checkbox"/> | Heart trouble        | <input type="checkbox"/> | <input type="checkbox"/> | Kidney disease      | <input type="checkbox"/> | <input type="checkbox"/> |

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 _____ | _____       |