

2004 Cub Scout Day Camp – Registration Form

Fill in the session(s) for the Cub Scout Day Camp(s) and Date(s) you are registering for.

Session: _____ Pack#: _____ Today's Date: _____ Son's Date of Birth: _____ Grade in next School Year: _____

Cub Scout's Name: _____ Day Time Phone #: (_____) _____ - _____

Parent's Name: _____ Evening Phone #: (_____) _____ - _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Current Rank (For LDS Units Only): _____ Parent's Email Address: _____

Fees for registrations received on or before cut off date.	_____ X \$65.00	=	_____
Fees for registrations received after cut off date.	_____ X \$80.00	=	_____
One Free T-Shirt Size → Check off Sizes Below	\$0.00	=	\$0.00
Extra T-Shirts	_____ X \$7.00	=	_____
	Total Due	=	_____

Youth T-shirt Sizes & Quantity *SORRY, NO SHIRT EXCHANGES* _____ <input type="checkbox"/> Youth size 10-12 _____ <input type="checkbox"/> Youth size 14-16 _____ <input type="checkbox"/> Adult M _____ <input type="checkbox"/> Adult L _____ <input type="checkbox"/> Adult XL	Adult Staff T-shirt Size & Quantity (Full time staff who work all 5 days receive one free t-shirt) _____ <input type="checkbox"/> Adult S _____ <input type="checkbox"/> Adult M _____ <input type="checkbox"/> Adult L _____ <input type="checkbox"/> Adult XL _____ <input type="checkbox"/> Adult XXL _____ <input type="checkbox"/> Adult 3XL
--	--

HEALTH FORM

IN CASE OF EMERGENCY NOTIFY: _____ at Phone (_____) _____ - _____

OR CONTACT (Name): _____ Relation: _____ at Phone (_____) _____ - _____

Family Physician: _____ Phone(_____) _____

HEALTH HISTORY

Have or subject to: (check all that apply) <input type="checkbox"/> Asthma <input type="checkbox"/> Fainting Spells <input type="checkbox"/> Convulsions <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Trouble <input type="checkbox"/> Insect Bites: (what type?) _____ <input type="checkbox"/> Food Allergies: (what type?) _____ <input type="checkbox"/> Sports / Activity Restrictions: (specify) _____ <input type="checkbox"/> Other (specify) _____	Have difficulty with: (check all that apply) <input type="checkbox"/> Eyes (Glasses or Contacts) <input type="checkbox"/> Ears (Hearing Aide? _____) <input type="checkbox"/> Nose <input type="checkbox"/> Digestion <input type="checkbox"/> Throat <input type="checkbox"/> Lungs <input type="checkbox"/> Currently taking medication Check box if your son is taking medication. Name of medication: _____ <i>If your son is taking medication there is an additional form that must be completed prior to camp. The form will be given to you when the Camp Director has received this notification.</i>
--	--

PARENT AUTHORIZATION

This health history 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 and the physician. In the event I cannot be reached in an emergency, I hereby give permission to the physician, selected by the Camp Director or Health Officer or other adult staff member, to hospitalize, secure proper anesthesia, or to order injection or surgery for my son.

Parent Authorization (signature): _____ Please Print Your Name Here: _____
 Date: ____/____/____ **THIS FORM MUST BE SIGNED BY A PARENT TO BE VALID.**

RECEIVE A \$25.00 REFUND IF YOU JOIN OUR STAFF.

Staff members are volunteer parents like yourself who volunteer their time to make Day Camp a memorable experience for their son. We are asking parents to work on staff or at least give some time to the program. (Staff who work for all five days receive a Free T-shirt and a \$25.00 refund)

Please choose an option below.

Yes, I will work as a Cub Day Camp Volunteer Circle the days you are available: Mon. Tue. Wed. Thur. Fri. or All Five Days
 (The \$25.00 refund will be mailed to you by August for those who volunteer all five days)

Return Completed Form and Payment to: Central Florida Council, Wayne Densch Scout Service Center,
 1951 South Orange Blossom Trail, Suite 102, Apopka, FL 32703 OR FAX 407-889-4406 if paying by Credit Card

MAKE CHECK PAYABLE TO: CENTRAL FLORIDA COUNCIL, B.S.A.

(FEES DO NOT INCLUDE ACCIDENT OR SICKNESS INSURANCE)

CASH OR CHECK	CHECK #	AMOUNT \$
VISA OR MASTERCARD		
EXPIRATION DATE ____/____/____	SIGNATURE: _____	

Payment with charge may be faxed to 407-889-4406 Direct Mail Account # F018-Session# _____