

MEDICAL AUTHORIZATION

This health history is correct so far as I know. I authorize the On-site Health Officer (Nurse) of the Piedmont District Cub Scout Day Camp to act for me according to the best judgment for any emergency requiring minor medical attention and any medication listed by me in this health record. All other attention will be referred to a medical physician.

**Chaperone
must sign below:**

Signed: _____

Date: _____

**CHAPERONE APPLICATION
AND
HEALTH RECORD
For
Piedmont District Cub Scout Day Camp
2008**

A chaperone is defined as an adult 21 years or older, usually a parent/guardian of an attending scout that volunteer for one or more days to help supervise all scouts in a particular den. It is not required that a chaperone attend each day.

Chaperones do not receive discounts on camp fees and do not receive camp tee shirts.

NAME: _____
Pack _____ **Troop** _____ **Crew** _____ **Ship** _____
Unit #: _____ **District:** _____

Day(s) of week you are working:

Please check all days that apply

Monday _____
Tuesday _____
Wednesday _____
Thursday _____
Friday _____

(Information below to be completed by Camp Staff)

Chaperone Work Area: _____
Scout's Name: _____
Scout's Den Name: _____



CHAPERONE APPLICATION
2008 Piedmont District CUB SCOUT DAY CAMP

(ONE NAME PER APPLICATION)
First Name: _____ Last Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Birthdate: ___/___/___ Pack/District/Council Position: _____
Spouse's Name: _____ Phone#: _____
Home Phone#: _____ Cell Phone#: _____ Email: _____

ACTIVITY AREAS OF INTEREST AND /OR QUALIFICATIONS:

_____ Crafts _____ Nature _____ Nature Trail
_____ Music _____ Scout Skills _____ Games
_____ BB's _____ Archery _____ Medical Staff
_____ Registration _____ Other _____

PLEASE COMPLETE INFORMATION BELOW:

Are you a BSA registered member?: _____yes _____no
Have you received BSA Youth Protection training?:
_____yes _____no Date: _____
CPR certified?: _____yes _____no Date Certified: _____
Trained in American Red Cross First Aid?:
_____yes _____no Date: _____
Attended BSA National Camp School?: _____yes _____no
Date: _____
Scouting experience (in years): _____youth _____adult
Please list any day camp experience:

Chaperone Signature: _____ Date: _____

HEALTH RECORD

Please PRINT and Fill in ALL blanks below:

Name: _____ Age: _____
IN CASE OF EMERGENCY NOTIFY:
Spouse: _____ Phone: (H) _____
Cell: _____ (B) _____
Mother: _____ Phone: (H) _____
Cell: _____ (B) _____
Father: _____ Phone: (H) _____
Cell: _____ (B) _____
Guardian: _____ Phone: (H) _____
Cell: _____ (B) _____
Physician: _____ Phone: _____
Cell: _____ (B) _____
Other instructions: attach extra sheet if necessary

NOW HAS OR IS SUBJECT TO: (Check if Yes)

Asthma Heart Trouble _____
 Diabetes Other _____
 Fainting Sports Restrictions _____
 Seizures Allergies _____
 ADHD or ADD _____

Explain any item checked above:

Any condition now requiring medication: _____ YES _____ NO
If yes, Name of Medication: _____
Is the Medication with him/her?: _____ YES _____ NO
If NO, who has it? _____
If YES, what restrictions: _____