

SANTA MARGARITA DISTRICT, S.D.I.C.
Cub Scout Summer Day Camp - Vista
Wild West Adventure: 12-16 July 2010
Application Forms

Attached you will find the forms for cub scout day camp. Please Fill out all necessary forms. I will need a completed BSA Medical for each person attending camp(Cubs, Volunteers, Siblings).

Please keep in mind the following items.

- **Registration Begins at the April 8th Roundtable in Vista at 6:30 pm or by mail(after the 8th).**
- **Only mailed in or hand delivered forms will be accepted. E-mailed applications and forms can not be accepted.**
- **Space availability determined on a first come first serve basis. No reservations accepted.**
- **Please indicate your son's rank as of September 1st, 2010.**
- **If you commit to volunteer at camp please keep your commitment. If you can not please let me know ASAP and maybe find someone to fill your position.**

Please be patient. I will start to e-mail people as the registrations come in to notify that your son has secured a spot at camp.

If we fill up I will start a waiting list. I will notify persons that are in this position and follow through on what they would like to do.

Lastly, All registration is going though me this year to avoid mix ups with council. This should ensure smother and more timely communication.

Thank You,
Ron Anderson
Camp Director
Vista Day Camp
randerson12@cox.net

Vista Day Camp

SANTA MARGARITA DISTRICT, S.D.I.C.
Cub Scout Summer Day Camp - Vista
Wild West Adventure: 12-16 July 2010
Cub Scout Application Form

Boy's name (please print): _____

Date of birth (mm/dd/yy): ____/____/____

Address: _____ City: _____ ZIP: _____

Home phone: (____) _____ - _____ Cell phone: (____) _____ - _____

Pack #: _____ Den # or name: ____ Leader's Name: _____

School grade in the Fall 2010: _____

What will be your son's rank on September 1st, 2010? Tiger Wolf Bear Webelos I Webelos II

(All boys will receive a camp T-shirt on a date prior to the first day of camp; participation patch on Friday.)

Circle T-shirt size: Youth M(10-12) Youth L(14-16) Adult S Adult M Adult L

Parent/Guardian Names (please print): _____

E-mail address (only for camp communications): _____

I, (name) _____, agree to volunteer my services at the 2010 Santa Margarita District Vista Cub Camp. Discounts are listed below.

2 DAYS (\$20 discount) **3 DAYS** (\$35 discount) **4 DAYS** (\$50 discount) **5 DAYS** (\$60 discount)
(Circle: M T W TH F *All Week*)

Discount applies to only one scout. Additional scouts in the same family will pay full price.

****Director cannot guarantee that each volunteer will be placed in the same den as their Scout.****

*******IMPORTANT******* A camp confirmation packet will be sent prior to the start of camp confirming your Scout's place in camp. If you do not receive a confirmation packet, please contact me via e-mail at randerson12@cox.net

- I have completed this application and the BSA health form A & C for each scout attending camp.
- I have enclosed the registration fee of \$95.00 per scout. (See above for discount information)
- I have registered before the deadline of June 3rd, 2010. **If I register after this time my scout is not guaranteed a spot in the camp. There are no registrations on the day of camp.**
- My son has permission to have his photo taken for public relations purposes.
- I will mail this application and check to . **Ron Anderson 1470 Alta Vista Dr Vista, CA 92084**
Make checks payable to "BSA ACCT. #1-6801-835-20"

Parent/Guardian Signature _____ Date _____

For questions or information, contact:
Ron Anderson, Cub Camp Director *760-224-9117* randerson12@cox.net

SANTA MARGARITA DISTRICT, S.D.I.C.
Wild West Adventure: Cub Day Camp 2010
VOLUNTEER STAFF FORM

Name (please print): _____ Date of birth: ____/____/____

Address: _____ City: _____ ZIP: _____

Home phone: (____) _____ - _____ Cell phone: (____) _____ - _____

CA Driver's License #: _____

Have you previously served on this Camp Staff before? Yes No When: _____

Current Registered BSA Member? Yes No Position (if applicable): _____

Emergency Contact: _____ Phone: (____) _____ - _____

(If Volunteer is under 18)

Pack/Troop/Crew: _____ Council: _____ Current Rank: _____

Parent/Guardian's Name: _____ Phone: (____) _____ - _____

I am available to volunteer for camp on the following days (Please circle days):

2 DAYS (\$20 discount) **3 DAYS** (\$35 discount) **4 DAYS** (\$50 discount) **5 DAYS** (\$60 discount)

(Circle: **M T W TH F All Week**)

Discount applies to only one scout. Additional scouts in the same family will pay full price.

12-16 July 2010 M T W TH F **All Week** (\$60 discount!)

I have experience in the following areas: _____

T-shirt size (please circle one): Adult L Adult XL Adult 2XL Adult 3XL

I agree to serve as a volunteer, in a manner consistent with the Scout Oath and Law and Youth Protection Guidelines. **I also agree to the terms below:**

I understand that I may not be assigned to my son's den. I am choosing to volunteer in any capacity I am assigned to. I understand that my son's registration fee will be reduced in ratio to the number of days I can work at camp. (____) Initials

Volunteer Staff Member: _____ Date: _____

Parent's approval if under 18: _____ Date: _____

Mail this completed application to: Ron Anderson 1470 Alta Vista Dr. Vista, CA 92084

**SANTA MARGARITA DISTRICT, S.D.I.C.
CUB SCOUT SUMMER DAY CAMP 2010
SIBLINGS APPLICATION**

Since I will be volunteering to help at Cub Scout Summer Day Camp, I would like my son's sibling (one application per sibling) to attend the SIBLINGS PROGRAM (siblings can only attend the days you are volunteering):

DATE: 12-16 July 2010 Camp: (Please circle days) M T W Th F All Week
If Attending all week there will be a \$10 Fee (t-shirt & supplies)

FEE: Possibly \$10

Mail this completed application to: Ron Anderson 1470 Alta Vista Dr. Vista, CA 92084

Child's Name: _____

Age: _____

Address: _____ City: _____ Zip: _____

Parent/Guardian Name: _____

Phone: (H) (_____) _____ (W) (_____) _____ (Cell) (_____) _____

HEALTH HISTORY: Has or subject to: (check if yes) describe any items checked.

___ Asthma ___ Diabetes ___ Convulsions ___ Fainting Spells ___ Heart ___ Allergies ___

Other ___ Please Describe: _____

Has Difficulty with: (check if yes): ___ Ears ___ Eyes ___ Nose ___ Throat ___ Lungs
___ Digestion

Please Describe: _____

Any restrictions for medical reasons: _____

Any condition requiring medication: _____

Name of medication _____ Dosage _____

Please list all allergies: _____

Immunization Dates: ___ Tetanus Toxoid ___ Polio ___ Mumps ___

Diphtheria ___ Pertussis ___ Measles ___ Rubella

Family Physician _____ Phone _____

Medical Insurance Information (Company, policy number, phone number, etc.):

I have completed this application and the BSA health form A & C for each sibling attending camp.

My son/daughter has permission to have his photo taken for public relations purposes.

Signature of Parent/Guardian _____ **Date** _____

Annual BSA Health and Medical Record

Part A

GENERAL INFORMATION

Name _____ Date of birth _____ Age _____ Male Female
 Address _____ Grade completed (youth only) _____
 City _____ State _____ Zip _____ Phone No. _____
 Unit leader _____ Council name/No. _____ Unit No. _____
 Social Security No. (optional; may be required by medical facilities for treatment) _____ Religious preference _____
 Health/accident insurance company _____ Policy No. _____

ATTACH A PHOTOCOPY OF BOTH SIDES OF INSURANCE CARD (SEE PART C). IF FAMILY HAS NO MEDICAL INSURANCE, STATE "NONE."

In case of emergency, notify:

Name _____ Relationship _____
 Address _____
 Home phone _____ Business phone _____ Cell phone _____
 Alternate contact _____ Alternate's phone _____

MEDICAL HISTORY

Are you now, or have you ever been treated for any of the following:

Yes	No	Condition	Explain
		Asthma	
		Diabetes	
		Hypertension (high blood pressure)	
		Heart disease (i.e., CHF, CAD, MI)	
		Stroke/TIA	
		COPD	
		Ear/sinus problems	
		Muscular/skeletal condition	
		Menstrual problems (women only)	
		Psychiatric/psychological and emotional difficulties	
		Learning disorders (i.e., ADHD, ADD)	
		Bleeding disorders	
		Fainting spells	
		Thyroid disease	
		Kidney disease	
		Sickle cell disease	
		Seizures	
		Sleep disorders (i.e., sleep apnea)	
		GI problems (i.e., abdominal, digestive)	
		Surgery	
		Serious injury	
		Other	

Allergies or Reaction to:

Medication _____

Food, Plants, or Insect Bites _____

Immunizations:

The following are recommended by the BSA. Tetanus immunization must have been received within the last 10 years. If had disease, put "D" and the year. If immunized, check the box and the year received.

Yes	No	Date
<input type="checkbox"/>	<input type="checkbox"/>	Tetanus _____
<input type="checkbox"/>	<input type="checkbox"/>	Pertussis _____
<input type="checkbox"/>	<input type="checkbox"/>	Diphtheria _____
<input type="checkbox"/>	<input type="checkbox"/>	Measles _____
<input type="checkbox"/>	<input type="checkbox"/>	Mumps _____
<input type="checkbox"/>	<input type="checkbox"/>	Rubella _____
<input type="checkbox"/>	<input type="checkbox"/>	Polio _____
<input type="checkbox"/>	<input type="checkbox"/>	Chicken pox _____
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A _____
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B _____
<input type="checkbox"/>	<input type="checkbox"/>	Influenza _____
<input type="checkbox"/>	<input type="checkbox"/>	Other (i.e., HIB) _____

Exemption to immunizations claimed.

MEDICATIONS

List all medications currently used. (If additional space is needed, please photocopy this part of the health form.) Inhalers and EpiPen information must be included, even if they are for occasional or emergency use only.

(For more information about immunizations, as well as the immunization exemption form, see [Scouting Safely on Scouting.org](#).)

Medication _____ Strength _____ Frequency _____ Approximate date started _____ Reason for medication _____ _____ Distribution approved by: _____ Parent signature _____ / MD/DO, NP, or PA Signature Temporary <input type="checkbox"/> Permanent <input type="checkbox"/>	Medication _____ Strength _____ Frequency _____ Approximate date started _____ Reason for medication _____ _____ Distribution approved by: _____ Parent signature _____ / MD/DO, NP, or PA Signature Temporary <input type="checkbox"/> Permanent <input type="checkbox"/>	Medication _____ Strength _____ Frequency _____ Approximate date started _____ Reason for medication _____ _____ Distribution approved by: _____ Parent signature _____ / MD/DO, NP, or PA Signature Temporary <input type="checkbox"/> Permanent <input type="checkbox"/>
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NOTE: Be sure to bring medications in the appropriate containers, and make sure that they are NOT expired, including inhalers and EpiPens. You SHOULD NOT STOP taking any maintenance medication.

Emergency contact No.:

Allergies:

DOB:

Last name:

Part C

Informed Consent and Hold Harmless/Release Agreement

I understand that participation in Scouting activities involves a certain degree of risk. I have carefully considered the risk involved and have given consent for myself and/or my child to participate in these activities. I understand that participation in these activities is entirely voluntary and requires participants to abide by applicable rules and standards of conduct. I release the Boy Scouts of America, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with the activity from any and all claims or liability arising out of this participation.

I approve the sharing of the information on this form with BSA volunteers and professionals who need to know of medical situations that might require special consideration for the safe conducting of Scouting activities.

In case of an emergency involving me or my child, I understand that every effort will be made to contact the individual listed as the emergency contact person. In the event that this person cannot be reached, permission is hereby given to the medical provider selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for me or my child. Medical providers are authorized to disclose to the adult in charge Protected Health Information/ Confidential Health Information (PHI/CHI) under the Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. §§160.103, 164.501, etc. seq., as amended from time to time, including examination findings, test results, and treatment provided for purposes of medical evaluation of the participant, follow-up and communication with the participant's parents or guardian, and/or determination of the participant's ability to continue in the program activities.

- Without restrictions.
- With special considerations or restrictions (list) _____

I hereby assign and grant to the local council and 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 all Scouting activities, and I hereby release the Boy Scouts of America, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with the activity from any and all liability from such use and publication.

I hereby authorize the reproduction, sale, copyright, exhibit, broadcast, electronic storage, and/or distribution of said photographs/ film/videotapes/electronic representations 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.

- Yes No

Adults authorized to take youth to and from the event: (You must designate at least one adult. Please include a telephone number.)

Adults NOT authorized to take youth to and from the event:

- 1. _____
- 2. _____
- 3. _____

- 1. _____
- 2. _____
- 3. _____

I understand that, if any information I/we have provided is found to be inaccurate, it may limit and/or eliminate the opportunity for participation in any event or activity.


Participant's name _____

Participant's signature _____

Parent/guardian's signature _____
(if under the age of 18)

Date _____

Attach copy of insurance card (front and back) here. If required by your state, use the space provided here for notarization.



BOY SCOUTS OF AMERICA
1325 West Walnut Hill Lane
P.O. Box 152079
Irving, Texas 75015-2079
<http://www.scouting.org>

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Part C Last name: _____ **DOB:** _____