

# THE ADVENTURE BEGINS

POKAGON DISTRICT DAY CAMP 2019  
VOLUNTEER FORM



BIXLER LAKE, KENDALVILLE

JUNE 24-26, 2019

EARLY BIRD REGISTRATION \$50 BY MAY 31ST, 2019  
(AFTER MAY 31ST \$65)

*REGISTRATIONS MADE AFTER MAY 31ST  
WILL NOT INCLUDE A T-SHIRT.*

*T-SHIRTS ARE A FIRST COME FIRST SERVE BASIS.  
ADDITIONAL T-SHIRTS MAY BE PURCHASED AT CHECK IN IF AVAILABLE.*

CHECK IN STARTS AT 8:15 AM ON JUNE 24TH, WITH CAMP STARTING AT 9:00 AM.

ON JUNE 25TH AND 26TH DROP-OFF BEGINS AT 8:30 AM, WITH CAMP STARTING AT 9:00 AM.

EACH DAY WE WILL FINISH UP CAMP AT 4:30PM.

USE THE ATTACHED FORM OR CONTACT CAMP DIRECTOR  
DAVE MANN AT 260-585-9853 OR AT [HANDYMANN7@GMAIL.COM](mailto:HANDYMANN7@GMAIL.COM)

TIFFANY PARKER AT 317-908-2415 OR AT  
[TIFFANYCONRAD@ROCKETMAIL.COM](mailto:TIFFANYCONRAD@ROCKETMAIL.COM)

### Staff/ Group Helper Registration For Day Camp

Choose One: \_\_\_Staff(over 21) \_\_\_Tiger Parent \_\_\_Group Helper(14-21 yrs old)

Name\_\_\_\_\_ Age\_\_\_\_\_ Pack/Troop #\_\_\_\_\_

Address\_\_\_\_\_

City\_\_\_\_\_ State \_\_\_ Zip\_\_\_\_\_ Phone\_\_\_\_\_

Email\_\_\_\_\_

Are you a registered scouter? \_\_\_Yes \_\_\_ No Gender: Male / Female

Position you are applying for:

\_\_\_Walker \_\_\_Station Help \_\_\_Tot lot

Which days are you available to volunteer at Day Camp? June 24 \_\_\_\_\_ June 25 \_\_\_\_\_ June 26 \_\_\_\_\_

If you wish to be in a group with your scout, write their name here:

\_\_\_\_\_

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

Parent Signature (If under 18)\_\_\_\_\_

Print Name\_\_\_\_\_ Date\_\_\_\_\_

### Day Camp T-shirt Order Form

One shirt free to volunteers for 3 days of helping at Day Camp.

Youth Large\_\_\_\_\_ Adult Small\_\_\_\_\_ Adult Medium\_\_\_\_\_ Adult Large\_\_\_\_\_

Adult XLarge\_\_\_\_\_ Adult 2XLarge\_\_\_\_\_ Adult 3XLarge\_\_\_\_\_ Adult 4XLarge\_\_\_\_\_

(2XL and larger are \$3 extra) Total Due\_\_\_\_\_

**ALL CAMPERS AND STAFF MUST HAVE PARTS A & B OF THE SCOUT PHYSICAL FOR ATTACHED TO APPLICATION!**

IN CASE OF EMERGENCY NOTIFY:

NAME\_\_\_\_\_ RELATIONSHIP\_\_\_\_\_

PHONE\_\_\_\_\_ FAMILY DOCTOR\_\_\_\_\_

### TALENT RELEASE

I hereby assign and grant the Anthony Wayne Area Council, Boy Scouts of America, the right and permission to use and publish the photographs/ films/ video and other electronic representations to include sound recordings made during Day Camp. I hereby release Anthony Wayne Area Council, Boy Scouts of America, 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/ films/ video tapes/ electronic representations and/or sound recordings without limitation at the discretion of the Anthony Wayne Area Council, Boy Scouts of America, and I specifically waive any right to compensation I may have for any of the foregoing.

Signature\_\_\_\_\_

Date\_\_\_\_\_

## Part A: Informed Consent, Release Agreement, and Authorization

Full name: \_\_\_\_\_  
DOB: \_\_\_\_\_

**High-adventure base participants:**  
Expedition/crew No.: \_\_\_\_\_  
or staff position: \_\_\_\_\_

### Informed Consent, Release Agreement, and Authorization

I understand that participation in Scouting activities involves the risk of personal injury, including death, due to the physical, mental, and emotional challenges in the activities offered. Information about those activities may be obtained from the venue, activity coordinators, or your local council. I also understand that participation in these activities is entirely voluntary and requires participants to follow instructions and abide by all applicable rules and the standards of conduct.

In case of an emergency involving me or my child, I understand that efforts will be made to contact the individual listed as the emergency contact person by the medical provider and/or adult leader. 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 protected health information to the adult in charge, camp medical staff, camp management, and/or any physician or health-care provider involved in providing medical care to the participant. 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, includes 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.

(If applicable) I have carefully considered the risk involved and hereby give my informed consent for my child to participate in all activities offered in the program. I further authorize the sharing of the information on this form with any BSA volunteers or professionals who need to know of medical conditions that may require special consideration in conducting Scouting activities.

With appreciation of the dangers and risks associated with programs and activities, on my own behalf and/or on behalf of my child, I hereby fully and completely release and waive any and all claims for personal injury, death, or loss that may arise against the Boy Scouts of America, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with any program or activity.

I also hereby assign and grant to the local council and the Boy Scouts of America, as well as their authorized representatives, 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 further 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 BSA, and I specifically waive any right to any compensation I may have for any of the foregoing.



**NOTE: Due to the nature of programs and activities, the Boy Scouts of America and local councils cannot continually monitor compliance of program participants or any limitations imposed upon them by parents or medical providers. However, so that leaders can be as familiar as possible with any limitations, list any restrictions imposed on a child participant in connection with programs or activities below.**



List participant restrictions, if any:  None

\_\_\_\_\_

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. If I am participating at Philmont, Philmont Training Center, Northern Tier, Florida Sea Base, or the Summit Bechtel Reserve, I have also read and understand the supplemental risk advisories, including height and weight requirements and restrictions, and understand that the participant will not be allowed to participate in applicable high-adventure programs if those requirements are not met. The participant has permission to engage in all high-adventure activities described, except as specifically noted by me or the health-care provider. If the participant is under the age of 18, a parent or guardian's signature is required.

Participant's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/guardian signature for youth: \_\_\_\_\_ Date: \_\_\_\_\_

(If participant is under the age of 18)

Second parent/guardian signature for youth: \_\_\_\_\_ Date: \_\_\_\_\_

(If required; for example, California)

### Complete this section for youth participants only:

#### Adults Authorized to Take to and From Events:

You must designate at least one adult. Please include a telephone number.

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

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

Telephone: \_\_\_\_\_

Telephone: \_\_\_\_\_

#### Adults NOT Authorized to Take Youth To and From Events:

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

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

Telephone: \_\_\_\_\_

Telephone: \_\_\_\_\_



## Part B: General Information/Health History

**Full name:** \_\_\_\_\_

**High-adventure base participants:**

Expedition/crew No.: \_\_\_\_\_

or staff position: \_\_\_\_\_

**DOB:** \_\_\_\_\_

Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Height (inches): \_\_\_\_\_ Weight (lbs.): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP code: \_\_\_\_\_ Telephone: \_\_\_\_\_

Unit leader: \_\_\_\_\_ Mobile phone: \_\_\_\_\_

Council Name/No.: \_\_\_\_\_ Unit No.: \_\_\_\_\_

Health/Accident Insurance Company: \_\_\_\_\_ Policy No.: \_\_\_\_\_



**Please attach a photocopy of both sides of the insurance card. If you do not have medical insurance, enter "none" above.**



**In case of emergency, notify the person below:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Home phone: \_\_\_\_\_ Other phone: \_\_\_\_\_

Alternate contact name: \_\_\_\_\_ Alternate's phone: \_\_\_\_\_

### Health History

Do you currently have or have you ever been treated for any of the following?

Yes	No	Condition	Explain
		Diabetes	<b>Last HbA1c percentage and date:</b>
		Hypertension (high blood pressure)	
		Adult or congenital heart disease/heart attack/chest pain (angina)/heart murmur/coronary artery disease. Any heart surgery or procedure. Explain all "yes" answers.	
		Family history of heart disease or any sudden heart-related death of a family member before age 50.	
		Stroke/TIA	
		Asthma	<b>Last attack date:</b>
		Lung/respiratory disease	
		COPD	
		Ear/eyes/nose/sinus problems	
		Muscular/skeletal condition/muscle or bone issues	
		Head injury/concussion	
		Altitude sickness	
		Psychiatric/psychological or emotional difficulties	
		Behavioral/neurological disorders	
		Blood disorders/sickle cell disease	
		Fainting spells and dizziness	
		Kidney disease	
		Seizures	<b>Last seizure date:</b>
		Abdominal/stomach/digestive problems	
		Thyroid disease	
		Excessive fatigue	
		Obstructive sleep apnea/sleep disorders	<b>CPAP: Yes <input type="checkbox"/> No <input type="checkbox"/></b>
		List all surgeries and hospitalizations	<b>Last surgery date:</b>
		List any other medical conditions not covered above	



## Part B: General Information/Health History

Full name: \_\_\_\_\_  
 DOB: \_\_\_\_\_

**High-adventure base participants:**  
 Expedition/crew No.: \_\_\_\_\_  
 or staff position: \_\_\_\_\_

### Allergies/Medications

Are you allergic to or do you have any adverse reaction to any of the following?

Yes	No	Allergies or Reactions	Explain	Yes	No	Allergies or Reactions	Explain
		Medication				Plants	
		Food				Insect bites/stings	

List all medications currently used, including any over-the-counter medications.

CHECK HERE IF NO MEDICATIONS ARE ROUTINELY TAKEN.  IF ADDITIONAL SPACE IS NEEDED, PLEASE INDICATE ON A SEPARATE SHEET AND ATTACH.

Medication	Dose	Frequency	Reason

YES  NO Non-prescription medication administration is authorized with these exceptions: \_\_\_\_\_

Administration of the above medications is approved for youth by:

\_\_\_\_\_/\_\_\_\_\_  
 Parent/guardian signature MD/DO, NP, or PA signature (if your state requires signature)

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**Bring enough medications in sufficient quantities and in the original containers. Make sure that they are NOT expired, including inhalers and EpiPens. You SHOULD NOT STOP taking any maintenance medication unless instructed to do so by your doctor.**

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### Immunization

The following immunizations are recommended by the BSA. Tetanus immunization is required and must have been received within the last 10 years. If you had the disease, check the disease column and list the date. If immunized, check yes and provide the year received.

Yes	No	Had Disease	Immunization	Date(s)	Please list any additional information about your medical history:
			Tetanus		
			Pertussis		
			Diphtheria		
			Measles/mumps/rubella		
			Polio		
			Chicken Pox		
			Hepatitis A		
			Hepatitis B		
			Meningitis		
			Influenza		
			Other (i.e., HIB)		
			Exemption to immunizations (form required)		

**DO NOT WRITE IN THIS BOX**  
 Review for camp or special activity.

Reviewed by: \_\_\_\_\_

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

Further approval required:  Yes  No

Reason: \_\_\_\_\_

Approved by: \_\_\_\_\_

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



**CAMP CHIEF LITTLE TURTLE SPECIAL DIETARY CONSIDERATION/RESTRICTIONS**

Camp Chief Little Turtle tries to accommodate special dietary needs of Scouts and Scouters. Certain specialized needs will require parental or leadership support to ensure that dietary needs can be adequately met.

**Scout/Scouter Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_ **Session** \_\_\_\_\_

**Any food allergies (including milk protein allergy)?** \_\_\_\_Yes \_\_\_\_No. If yes, please explain, list each allergy, including type/severity of reaction:

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**Is cross-contamination with small amounts of potentially allergy-producing food items a concern?** \_\_\_\_Yes \_\_\_\_No

**Is an Epi-pen required for any of these food allergies?** \_\_\_\_ Yes \_\_\_\_No. If yes, which ones?

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**Aside from food allergies, are there any other dietary restrictions? If yes, please list:**

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Does Scout or Scouter have a specific medically-prescribed diet? If yes, please list:

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**Does Scout or Scouter have any physical disabilities and/or conditions that make eating and/or drinking difficult?** If yes, please explain below, including accommodations that need to be made while your child is at camp:

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**Are there any other special considerations or insights we should know about the Scout's or Scouter's dietary restrictions/concerns?** If so, please explain:

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11/10/14ns

