

**BE SURE TO GET
REGISTERED FOR
POKAGON DISTRICT'S
DAY CAMP BY JUNE 1ST!**

**Register at
www.awac.org
for on-line
registration!**



***POKAGON CUB SCOUT
DAY CAMP
REGISTRATION PACKET
ANTHONY WAYNE AREA COUNCIL
JUNE 14-15, 2021***

Keep this page for your information!

Program: What will your Scout do at Day Camp? We've got an archery range, arts & crafts, BB range, nature hikes, games, Scout skills, history, acting, singing, activities, imagination exploration, and many surprises! While doing these FUN things, he'll learn self-confidence, build friendships, live the Cub Scout Motto "Do Your Best," and experience new things. Cub Scout Day Camp is a terrific learning experience, and they'll learn MORE if a parent is there with them! Each district's day camp offers a different set of experiences. Feel free to contact your District's Day Camp Director for specifics!

COVID Policies: All necessary covid protocols will be followed. In order to assist with this, each Cub will be with their own Pack through the duration of Camp.

What to Bring:

- Pack a sack lunch with your Scout's full name on it. Refrigeration is not available.
- Insect repellent - wipes recommended.
- Sun block - wipes recommended.
- A Cub Scout hat.
- Rain gear. Dress for the weather.
- Water bottle.
- Be sure to wear the right shoes! You will be doing too much walking at camp to wear flip-flops or crocs.

PLEASE DO NOT BRING KNIVES OR ELECTRONICS!

Medications required by the Scout must be labeled with the Scout's full name and phone number, and must be taken to the Camp Health Officer each day. It is the responsibility of the Scout or parent to administer medications at required times. Day Camp Staff, other than the Health Officer, CANNOT dispense medicine. **Rescue inhalers, Allergy Antidotes, or other EMERGENCY medications** that must be carried with the Scout are to be labeled with the Scout's name and phone number and shall be carried by an ADULT leader with the group.

Keep this page for your information!

Adult Supervision: Return this completed form to your Cubmaster or Pack Day Camp Coordinator. To adequately staff Day Camp, we need an adult ratio of one adult for every six scouts. A minimum of one adult is needed from your Pack, even if you only send one Scout. Different adults can help each day, so many of your families can share visits to camp!

Tiger Cubs: If you are a new Tiger Cub (you will be entering 1st Grade in the Fall) you must have an adult partner with you at Day Camp at all times! The same adult partner does not have to attend each day.

Transportation: Each Pack needs to provide its own transportation to and from Day Camp. Talk to your Cubmaster or Pack Day Camp Coordinator about carpool arrangements for your Pack.

Trading Post: Your Day Camp may have a trading post or snack shack, so you may wish to bring a few dollars to camp. Check with your Cubmaster, Pack Day Camp Coordinator, or District Day Camp Director for details.

Fees and payment: The fee for Day Camp is just \$45.

Refunds: Refund forms are available at the office. Refunds may be given for serious illness, injury and deaths in the immediate family only with approval of the Council Program Camping Committee Chairman.

How to Sign Up: Turn in your completed registration with your fees to Anthony Wayne Area Council (8315 W Jefferson Blvd, Fort Wayne, IN 46804) or to your Cubmaster or Pack Day Camp coordinator. **Or Register online at <https://scoutingevent.com/157-PokagonDistrictDayCamp2021>**

INDIVIDUAL SCOUT REGISTRATION FOR DAY CAMP

ONE FORM PER PERSON

We recommend that all registrations from your Pack need to be submitted as a group, with an adult ratio of one adult for every six scouts. See "adult supervision" on the previous page for details.

CHOOSE ONE: **Cub Scout*** **Staff **** **Group Helper**** (14-21 yrs old)
* - Tiger Cubs (1st graders in the Fall 2021) must have an adult present with them at Camp and fill out a Staff Registration Form
** - All Staff and Group Helpers are required to have Youth Protection training available at www.scouting.org

Name: _____ Pack #: _____ Grade Completed (June 2011): _____

Address: _____ City: _____ Zip: _____

Home Phone: (____) _____ Age : _____ Email : _____

CAMP FEES

Regular Day Camp Fee \$ 45.00

Make checks payable to AWAC with Scout's name on the check in the "memo" section. Mail to :

AWAC
8315 W Jefferson Blvd,
Fort Wayne, IN 46804

TO VOLUNTEER TO WORK AT CAMP, PLEASE FILL OUT A SEPARATE REGISTRATION FORM!

CAMPER RELEASE AUTHORIZATION

The below signature authorizes **ONLY** the following people to pick up my child from Day Camp: **IF A PERSCOUT IS NOT LISTED, THEY WILL NOT BE ALLOWED TO TAKE YOUR CHILD HOME UNTIL WE HAVE CONTACTED YOU BY PHONE, EVEN IF THE PERSON CLAIMS TO BE A LEGAL CUSTODIAL PARENT OR GUARDIAN.** Without this form, we are ONLY allowed to release your Scout to the person who signed his camp application. This is a new child safety regulation - please understand that we do not have the ability to make exceptions. Thank you for understanding!

Name _____ Name _____

Name _____ Name _____

MEDICAL AUTHORIZATION

All regular medications must be kept at the First Aid Station and the Scout must pick them up from the Camp Health Officer at the required time and take it themselves. Other Day Camp Staff cannot dispense medicine.

PARENTAL AUTHORIZATION

The person herein described has permission to engage in all activities, except as noted above. In the event I cannot be reached in an emergency, I hereby give permission to the physician, selected by the leader in charge, to hospitalize, secure proper anesthesia, or to order injection or surgery for my Scout.

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 any other electronic representations to include sound recordings made of me during my stay at a Anthony Wayne Area Council event. I hereby release the 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/film/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: _____

Date of birth: _____

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.

Every person who furnishes any BB device to any minor, without the express or implied permission of the parent or legal guardian of the minor, is guilty of a misdemeanor. (California Penal Code Section 19915[a]) My signature below on this form indicates my permission.

I give permission for my child to use a BB device. (Note: Not all events will include BB devices.)

Checking this box indicates you DO NOT want your child to use a BB device.



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 Scout Ranch, Philmont Training Center, Northern Tier, 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)

Complete this section for youth participants only:

Adults Authorized to Take Youth to and From Events:

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

Name: _____

Name: _____

Phone: _____

Phone: _____

Adults **NOT** Authorized to Take Youth to and From Events:

Name: _____

Name: _____

Phone: _____

Phone: _____



Part B1: General Information/Health History

Full name: _____

Date of birth: _____

High-adventure base participants:

Expedition/crew No.: _____

or staff position: _____

Age: _____ Gender: _____ Height (inches): _____ Weight (lbs.): _____

Address: _____

City: _____ State: _____ ZIP code: _____ Phone: _____

Unit leader: _____ Unit leader's mobile #: _____

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	Last HbA1c percentage and date: _____ Insulin pump: Yes <input type="checkbox"/> No <input type="checkbox"/>
		Hypertension (high blood pressure)	
		Adult or congenital heart disease/heart attack/chest pain (anginal)/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/reactive airway disease	Last attack date: _____
		Lung/respiratory disease	
		COPD	
		Ear/eyes/nose/sinus problems	
		Muscular/skeletal condition/muscle or bone issues	
		Head injury/concussion/TBI	
		Altitude sickness	
		Psychiatric/psychological or emotional difficulties	
		Neurological/behavioral disorders	
		Blood disorders/sickle cell disease	
		Fainting spells and dizziness	
		Kidney disease	
		Seizures or epilepsy	Last seizure date: _____
		Abdominal/stomach/digestive problems	
		Thyroid disease	
		Skin issues	
		Obstructive sleep apnea/sleep disorders	CPAP: Yes <input type="checkbox"/> No <input type="checkbox"/>
		List all surgeries and hospitalizations	Last surgery date: _____
		List any other medical conditions not covered above	



Part B2: General Information/Health History

Full name: _____

Date of birth: _____

High-adventure base participants:

Expedition/crew No.: _____

or staff position: _____

Allergies/Medications

DO YOU USE AN EPINEPHRINE AUTOINJECTOR? Exp. date (if yes) _____ YES NO

DO YOU USE AN ASTHMA RESCUE INHALER? Exp. date (if yes) _____ YES NO

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 list 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)

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.

Immunization

The following immunizations are recommended. 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)
			Tetanus	
			Pertussis	
			Diphtheria	
			Measles/mumps/rubella	
			Polio	
			Chicken Pox	
			Hepatitis A	
			Hepatitis B	
			Meningitis	
			Influenza	
			Other (i.e., HIB)	
			Exemption to immunizations (form required)	

Please list any additional information about your medical history:

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

Reviewed by: _____

Date: _____

Further approval required: Yes No

Reason: _____

Approved by: _____

Date: _____

