

PARENT INFORMATION

2019 FRONTIER TRAILS CUB SCOUT DAY CAMPS - CENTRAL

Register for 1 or 2 or all 3!

Scoutwatts Academy – July 27
Scouters of the Lost Golden Knot – August 17
Little Pack on the Prairie – October 5-6

Scoutwatts Academy

WHEN: July 27 - Saturday
WHERE: General Sibley Park
5001 South Washington Street – Bismarck 58504
TIME: 8-9 Check In
9-5 Activities
5 Check Out
COST: \$35 By July 13 / \$40 After July 13
REGISTER: <https://scoutingevent.com/429-27059>

Scouters of the Lost Golden Knot

WHEN: August 17 – Saturday
WHERE: McDowell Dam
1951 93 St NE – Bismarck - 58504
TIME: 8-9 Check In
9-4:45 Activities
4:45 Egg Drop
5 Check Out
COST: \$35 By August 3 / \$40 After August 3
REGISTER: <https://scoutingevent.com/429-27060>

Little Pack on the Prairie

WHEN: October 5-6 – Saturday/Sunday (parent required if camping overnight)
WHERE: Eagles Park
10900 Hwy 1804 – Bismarck 58503
TIME: 8-9 Check In (parents staying overnight may set up camp)
9-5 Activities
5-5:30 Check Out/Check In/Set Up Camp
5:30 Family Dinner
7:45 Campfire Program
10 Lights Out
8 AM Sun Breakfast/Break Camp/Check Out
COST: \$35 By September 21 / \$40 After September 21
REGISTER: <https://scoutingevent.com/429-27061>
OPTIONAL OVERNIGHTER: Families staying overnight must supply their own camping gear (tent, sleeping bag/pillow, change of clothes, flashlight...) Be prepared for cooler weather.
REGISTRATION INFO NEEDED: Scouts must have a parent present (no exceptions).
Family Dinner – How many people will be staying for dinner?
Overnight – Is scout staying overnight with family member?

Capital Credit Union Scout Center – 3320 Hamilton St #1 – Bismarck ND 58503 701-223-7204 bismarck@nlcbsa.org

General Information ALL adults will be station leaders/walking den leaders.

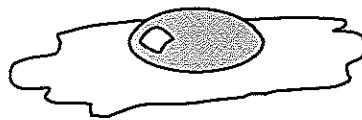
- 3 page medical form is attached & **must be completed by all youth & adults attending camp.** Return to your pack/Scout Center before camp starts (can also be scanned & emailed)
- Lunch, snacks & water provided.
- **Online pre-registration is required.** Follow the "Register" link provided for each day camp.

EGG DROP RULES

(only at "Scouters of the Lost Golden Knot" August Day Camp)

Here is a family project: Pack a single, raw, hen's egg so well that when it is dropped from the bucket of a truck, it will not break. Please abide by the following rules, so that it is fair to all:

1. You must use a raw chicken egg. It cannot be cooked or frozen. Eggs that do not break will be checked to be sure they are raw.
2. You may use some type of suspension system, as long as it is not fused onto the egg - or you may just pack the egg in some type of packing; jello, popcorn, crushed newspaper, plastic peanuts, etc. The egg cannot be coated with any type of material, such as a chemical, rubber latex or cement. NO PARACHUTES!!
3. The overall size of your container may not be more than 6"x6"x6". ALL BOXES WILL BE MEASURED AND THOSE TOO LARGE WILL NOT BE DROPPED.
4. Put your full name and pack number on the outside of the box.
5. You must stay away from the truck - there will be barriers that you must stay behind during the drop.
6. Once the boxes have been dropped, you will be able to retrieve the box/stuffing if needed.
7. A judging team will be on hand to check boxes after the drop and determine the winners.
8. GOOD LUCK!!



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

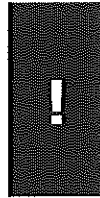
I understand that participation in Scouting activities involves the risk of personal injury, including death, due to the physical, mental, and emotional challenges in the activities offered. Information about those activities may be obtained from the venue, activity coordinators, or your local council. 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.

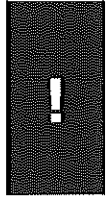
(If applicable) I have carefully considered the risk involved and hereby give my informed consent for my child to participate in all activities offered in the program. I further authorize the sharing of the information on this form with any BSA volunteers or professionals who need to know of medical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

DOB: _____

High-adventure base participants:
 Expedition/crew No.: _____
 or staff position: _____

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
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	Last HbA1c percentage and date:
<input type="checkbox"/>	<input type="checkbox"/>	Hypertension (high blood pressure)	
<input type="checkbox"/>	<input type="checkbox"/>	Adult or congenital heart disease/heart attack/chest pain (angina)/heart murmur/coronary artery disease. Any heart surgery or procedure. Explain all "yes" answers.	
<input type="checkbox"/>	<input type="checkbox"/>	Family history of heart disease or any sudden heart-related death of a family member before age 50.	
<input type="checkbox"/>	<input type="checkbox"/>	Stroke/TIA	
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	Last attack date:
<input type="checkbox"/>	<input type="checkbox"/>	Lung/respiratory disease	
<input type="checkbox"/>	<input type="checkbox"/>	COPD	
<input type="checkbox"/>	<input type="checkbox"/>	Ear/eyes/nose/sinus problems	
<input type="checkbox"/>	<input type="checkbox"/>	Muscular/skeletal condition/muscle or bone issues	
<input type="checkbox"/>	<input type="checkbox"/>	Head injury/concussion	
<input type="checkbox"/>	<input type="checkbox"/>	Altitude sickness	
<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric/psychological or emotional difficulties	
<input type="checkbox"/>	<input type="checkbox"/>	Behavioral/neurological disorders	
<input type="checkbox"/>	<input type="checkbox"/>	Blood disorders/sickle cell disease	
<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells and dizziness	
<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	
<input type="checkbox"/>	<input type="checkbox"/>	Seizures	Last seizure date:
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal/stomach/digestive problems	
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	
<input type="checkbox"/>	<input type="checkbox"/>	Excessive fatigue	
<input type="checkbox"/>	<input type="checkbox"/>	Obstructive sleep apnea/sleep disorders	CPAP: Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	List all surgeries and hospitalizations	Last surgery date:
<input type="checkbox"/>	<input type="checkbox"/>	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
<input type="checkbox"/>	<input type="checkbox"/>	Medication		<input type="checkbox"/>	<input type="checkbox"/>	Plants	
<input type="checkbox"/>	<input type="checkbox"/>	Food		<input type="checkbox"/>	<input type="checkbox"/>	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)

! 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 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)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tetanus	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pertussis	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diphtheria	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Measles/mumps/rubella	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Polio	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Meningitis	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Influenza	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (i.e., Hib)	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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: _____