



2008 Section NE-2C Conclave

August 22-24, 2008

Ten Mile River Scout Camps - Camp Keowa
 Service Council: Greater New York Councils - Brooklyn
 Shu-Shu-Gah Lodge #24



Print

Name: _____ **Lodge:** _____

Address: _____ **Telephone:** _____

City: _____ **State:** _____ **Zip Code:** _____

E-Mail: _____ **Birth Date:** ____ / ____ / ____

Honor: Ordeal ____ Brotherhood ____ Vigil ____ **Gender:** Male ____ Female ____
 Youth: _____ Adult: _____

Dietary/Medical Needs: _____

Registration Fee

Early Bird Registration: Payments received by June 1, 2008 - \$25.00

General Registration: Payments received by August 1, 2008 - \$30.00

Late Registration: Payments received after August 1, 2008 - \$35.00

Medical Forms **MUST** be brought with you to the Section Conclave

Please mail all conclave registration and Pre-Order to: Section NE-2C Conclave
 Greater New York Councils, BSA
 c/o Christopher Coscia
 350 5th Avenue, Suite 530
 New York, NY 10118

All Registration Closes on August 15, 2008

| Items | Price | Quantity | Amount |
|---|----------|----------|----------|
| Pocket Patch | \$ 5.00 | _____ | \$ _____ |
| Jacket Patch | \$ 12.00 | _____ | \$ _____ |
| Tee Shirt (L,XL,XXL) | \$ 11.00 | _____ | \$ _____ |
| Registration Fee (See fee schedule above) | | | \$ _____ |

Grand Total: \$ _____

All Checks must be made payable to: Greater New York Councils, BSA
 Please enter "Account #: 1-2371-201-00" in the Memo field

Shu-Shu-Gah use only : Date Received _____ Receipt _____ Entered _____

CLASS 1 PERSONAL MEDICAL HISTORY

PLEASE PRINT CLEARLY

Name: _____ Date of Birth: _____ Age: _____
Name of parent/guardian: _____ Telephone: _____
Home Address: _____ City: _____ State: _____ ZIP: _____
Business Address: _____ City: _____ State: _____ ZIP: _____

If person named above is not available in the event of an emergency, notify

Name: _____ Relationship: _____ Telephone: _____
Name: _____ Relationship: _____ Telephone: _____
Name of Personal Physician: _____ Telephone: _____
Personal health/accident insurance carrier: _____ Policy No. _____

In case of an emergency, I understand every effort will be made to contact me (If an adult, my spouse or next of kin). In the event I cannot be reached, I hereby give my permission to the physician selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medications for my child (or for me, if an adult)

Date: ___/___/___ Signature of parent/guardian or adult _____

Check **all** items that apply, past or present, to your health history. Explain any "Yes" answers.

ALLERGIES: Food, medicines, insects, plants, etc. Yes No Explain: _____

| General Information: | Yes | No | Yes | No | Yes | No | | |
|----------------------|--------------------------|--------------------------|---------------|--------------------------|--------------------------|---------------------|--------------------------|--------------------------|
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer/Leukemia | <input type="checkbox"/> | <input type="checkbox"/> | Heart Trouble | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Convulsions/seizures | <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Explain: _____

List any medications to be taken at camp: _____

List any physical or behavioral conditions that may affect or limit full participation all activities: _____

List equipment needed such as wheelchair, braces, glasses, contact lenses, etc. _____

Immunizations: (Give date of last inoculation)

Tetanus toxoid ___/___/___ Measles ___/___/___ Polio ___/___/___ Diphtheria ___/___/___

Mumps ___/___/___ Rubella ___/___/___ Pertussis ___/___/___

