



Ktemaque Lodge #15, Order of the Arrow, WWW

www.ktemaque.org

Westchester-Putnam Council, BSA

**2008 Fall Service Weekend**

September 19 - 21, 2008

Durland Scout Reservation at Clear Lake, Putnam Valley, NY

**Check-in:** Friday 8:00 p.m. to 10:00 p.m. at the Campmaster Cabin.  
Saturday 10:00 a.m. to 9:00 p.m. ONLY participants check in at the Jones Cabin.

**More information is on the Ktemaque Lodge web site at [www.ktemaque.org/](http://www.ktemaque.org/).**

Name \_\_\_\_\_ Telephone number (\_\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ Over 21 \_\_\_\_\_ Under 21 \_\_\_\_\_

Town \_\_\_\_\_ State \_\_\_\_\_ Zip+4 \_\_\_\_\_

Email address \_\_\_\_\_

- Member** (not a new candidate) **\$20.00** (\$15.00 if paid before September 12 deadline)
- Member** (Saturday 10 a.m. to 9 p.m. Only) **\$15.00** (\$10.00 if paid before September 12 deadline)
- Brotherhood Quest** **\$45.00** (\$40.00 if paid before September 12 deadline)  
(See requirements)
- Brotherhood Quest, Saturday only** **\$40.00** (\$35.00 if paid before September 12 deadline)
- Special Food – state restriction and attach note \_\_\_\_\_
- I have a ride.
- I can supply rides for \_\_\_\_\_ number of brothers.

Mail this registration form, the Personal Health and Medical Record Permission Slip form, and your check to the following, postmarked no later than **September 12, 2008**. Make your check payable to “Westchester-Putnam Council, BSA” and please write “**OA Account 1-2371-000-00**” on your check.

Ktemaque Lodge #15, WWW  
Westchester-Putnam Council, BSA  
41 Saw Mill River Road  
Hawthorne, NY 10532-1519

In the compliance with the American with Disabilities Act, Ktemaque Lodge #15, Order of the Arrow, WWW will make all the reasonable efforts to accommodate persons with disabilities at their activities. Please call the Scout Service Center (914) 773-1135 with your request.

If you have questions about the Fall Service Weekend, contact Clayton White, Lodge Chief at [hotsauce91@gmail.com](mailto:hotsauce91@gmail.com) or call Rob Carlson, Lodge Adviser at (914) 528-9331.

Office Use: Date Rec'd \_\_\_\_\_ Receipt # \_\_\_\_\_ Amount paid \$ \_\_\_\_\_



# PERSONAL HEALTH AND MEDICAL RECORD

## CLASS 1

**Ktemaque Lodge # 15, WWW Order of the Arrow**

Height \_\_\_\_\_ Weight \_\_\_\_\_ Eye color \_\_\_\_\_ Hair color \_\_\_\_\_

### CLASS 1 PERSONAL HEALTH AND MEDICAL HISTORY

To be filled out by parent, guardian, or adult participant. Please print in ink.

**IDENTIFICATION**

Name \_\_\_\_\_ Date of birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Name of parent or 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. \_\_\_\_\_

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

**ALLERGIES:** Food, medicines, insects, plants Yes  No  Explain: \_\_\_\_\_

<b>GENERAL INFORMATION:</b>	Yes	No	Yes	No	Yes	No		
ADHD (Attention-Deficit Hyperactivity Disorder)	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions/seizures	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
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"/>

Explain: \_\_\_\_\_

Please list ALL medications taken in the 30 days **prior** to arrival at the Scouting activity where this form is to be used: \_\_\_\_\_

List any **medications to be taken at camp**, including drug, dosage, route (oral, injection, etc.), and frequency: \_\_\_\_\_

List any physical or behavioral conditions that may affect or limit full participation in swimming, backpacking, hiking long distances, or playing strenuous physical games: \_\_\_\_\_

List equipment needed such as wheelchair, braces, glasses, contact lenses, etc.: \_\_\_\_\_

**Immunizations:** (Give date of last inoculation.)

Tetanus toxoid _____	Measles _____	Polio _____
OR DPT _____	OR MMR _____	_____
Hepatitis A _____	Varicella _____	OR Chicken pox _____
Hepatitis B _____	_____	_____

I give permission for full participation in BSA programs, subject to limitations noted herein.

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

Date \_\_\_\_\_ Signature of parent/guardian or adult \_\_\_\_\_

Date updated \_\_\_\_\_ Signature of parent/guardian or adult \_\_\_\_\_

Date updated \_\_\_\_\_ Signature of parent/guardian or adult \_\_\_\_\_

**Some hospitals require the parent/guardian signature to be notarized. Check with your BSA local council.**

NAME

TROOP

CAMP SITE