



Ktemaque Lodge #15, WWW
 Order of the Arrow
 Westchester-Putnam Council, BSA
Lodge Fellowship Weekend
April 1-3, 2011
 Durland Scout Reservation, Putnam Valley, NY

More information is on the Ktemaque Lodge web site at www.Ktemaque.org.

THREE FORMS are required to register for the Fellowship Weekend and/or Brotherhood Quest.

1. **This registration form**
 2. **Part A on page 2** of BSA medical form
 3. **Part C on page 4** of BSA medical form
- Signature is REQUIRED** on Part C on page 4 of BSA medical form.

These forms are available in **fillable format** at www.Ktemaque.org/forms.html.

Check-in: Friday 9:00 p.m. to 10:00 p.m. at the **Jones Cabin** We'll be staying in the Jones, Schutt, and Nardone cabins.
 Saturday 10 a.m. to 9 p.m. **ONLY** participants check-in anytime at the Jones Cabin.

Name _____ Home telephone number (_____) _____

Email address _____ Cellular phone number (_____) _____

Address _____ Under 21 Over 21

Town _____ State _____ Zip+4 _____

Member	\$15.00 (\$20.00 if paid after March 25 deadline)
Brotherhood Quest (See requirements)	\$40.00 (\$45.00 if paid after March 25 deadline)
Member (Saturday 10 a.m. to 9 p.m. only)	\$10.00 (\$15.00 if paid after March 25 deadline)
Brotherhood Quest (Saturday 10 a.m. to 9 p.m. only) (See requirements)	\$35.00 (\$40.00 if paid after March 25 deadline)

Special Food – state restriction and attach note _____

I have a ride. I can supply rides for _____ number of brothers, if needed.
 Yes, I want to be an **Elangomat** this weekend. Elangomat Training is available.
 Yes, I want to be on the **Ceremonial Team** this weekend. Training and regalia are available.
 Yes, I want to be a **photographer** this weekend.

Payment method (check one) **VISA** **MasterCard** **Check**
 Credit card number _____ Expiration Date _____
 Cardholder name (PRINT) _____ Total Amount: \$ _____
 Your signature is REQUIRED below to authorize the Westchester-Putnam Council, BSA to charge your credit card.
 Cardholder signature _____

If paying by check: Make your check payable to "**Westchester-Putnam Council, BSA**"
 Write "**OA Account 1-2371-000-00**" on your check.

Mail this form, Part A and Part C of the BSA medical form, and your payment (credit card information or check) postmarked no later than MARCH 25, 2011 to: 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 WWW, Order of the Arrow will make all the reasonable efforts to accommodate persons with disabilities at their activities. Please call the Westchester-Putnam Council Service Center (914) 773-1135 with your request.

If you have questions about the Fellowship Weekend, call Lodge Adviser Rob Carlson at (914) 528-9331.

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

Annual Health and Medical Record

(Valid for 12 calendar months)

Medical Information

The Boy Scouts of America recommends that all youth and adult members have annual medical evaluations by a certified and licensed health-care provider. In an effort to provide better care to those who may become ill or injured and to provide youth members and adult leaders a better understanding of their own physical capabilities, the Boy Scouts of America has established minimum standards for providing medical information prior to participating in various activities. Those standards are offered below in one three-part medical form. Note that unit leaders must always protect the privacy of unit participants by protecting their medical information.

Parts A and C are to be completed annually **by all BSA unit members**. Both parts are required for all events that do not exceed 72 consecutive hours, where the level of activity is similar to that normally expended at home or at school, such as day camp, day hikes, swimming parties, or an overnight camp, and where medical care is readily available. Medical information required includes a current health history and list of medications. Part C also includes the parental informed consent and hold harmless/release agreement (with an area for notarization if required by your state) as well as a talent release statement. Adult unit leaders should review participants' health histories and become knowledgeable about the medical needs of the youth members in their unit. This form is to be filled out by participants and parents or guardians and kept on file for easy reference.

Part B is required with parts A and C for any event that exceeds 72 consecutive hours, or when the nature of the activity is strenuous and demanding, such as a high-adventure trek. Service projects or work weekends may also fit this description. It is to be completed and signed by a certified and licensed health-care provider—physician (MD, DO), nurse practitioner, or physician's assistant as appropriate for your state. The level of activity ranges from what is normally expended at home or at school to strenuous activity such as hiking and backpacking. Other examples include tour camping, jamborees, and Wood Badge training courses. It is important to note that the height/weight limits must be strictly adhered to if the event will take the unit beyond a radius wherein emergency evacuation is more than 30 minutes by ground transportation, such as backpacking trips, high-adventure activities, and conservation projects in remote areas.

Risk Factors

Based on the vast experience of the medical community, the BSA has identified that the following risk factors may define your participation in various outdoor adventures.

- Excessive body weight
- Heart disease
- Hypertension (high blood pressure)
- Diabetes
- Seizures
- Lack of appropriate immunizations
- Asthma
- Sleep disorders
- Allergies/anaphylaxis
- Muscular/skeletal injuries
- Psychiatric/psychological and emotional difficulties

For more information on medical risk factors, visit Scouting Safely on www.scouting.org.

Prescriptions

The taking of prescription medication is the responsibility of the individual taking the medication and/or that individual's parent or guardian. A leader, after obtaining all the necessary information, can agree to accept the responsibility of making sure a youth takes the necessary medication at the appropriate time, but BSA does not mandate or necessarily encourage the leader to do so. Also, if state laws are more limiting, they must be followed.

For frequently asked questions about this Annual Health and Medical Record, see Scouting Safely online at <http://www.scouting.org/scoutsource/HealthandSafety.aspx>. Information about the Health Insurance Portability and Accountability Act (HIPAA) may be found at <http://www.hipaa.org>.



BOY SCOUTS OF AMERICA.

Annual BSA Health and Medical Record

Part A

GENERAL INFORMATION

Name _____ Date of birth _____ Age _____ Male Female
 Address _____ Grade completed (youth only) _____
 City _____ State _____ Zip _____ Phone No. _____
 Unit leader _____ Council name/No. _____ Unit No. _____
 Social Security No. (optional; may be required by medical facilities for treatment) _____ Religious preference _____
 Health/accident insurance company _____ Policy No. _____

ATTACH A PHOTOCOPY OF BOTH SIDES OF INSURANCE CARD (SEE PART C). IF FAMILY HAS NO MEDICAL INSURANCE, STATE "NONE."

In case of emergency, notify:

Name _____ Relationship _____
 Address _____
 Home phone _____ Business phone _____ Cell phone _____
 Alternate contact _____ Alternate's phone _____

MEDICAL HISTORY

Are you now, or have you ever been treated for any of the following:

Yes	No	Condition	Explain
		Asthma	
		Diabetes	
		Hypertension (high blood pressure)	
		Heart disease (i.e., CHF, CAD, MI)	
		Stroke/TIA	
		COPD	
		Ear/sinus problems	
		Muscular/skeletal condition	
		Menstrual problems (women only)	
		Psychiatric/psychological and emotional difficulties	
		Learning disorders (i.e., ADHD, ADD)	
		Bleeding disorders	
		Fainting spells	
		Thyroid disease	
		Kidney disease	
		Sickle cell disease	
		Seizures	
		Sleep disorders (i.e., sleep apnea)	
		GI problems (i.e., abdominal, digestive)	
		Surgery	
		Serious injury	
		Other	

Allergies or Reaction to:

Medication _____
 Food, Plants, or Insect Bites _____

Immunizations:

The following are recommended by the BSA. Tetanus immunization must have been received within the last 10 years. If had disease, put "D" and the year. If immunized, check the box and the year received.

Yes	No	Date
<input type="checkbox"/>	<input type="checkbox"/>	Tetanus _____
<input type="checkbox"/>	<input type="checkbox"/>	Pertussis _____
<input type="checkbox"/>	<input type="checkbox"/>	Diphtheria _____
<input type="checkbox"/>	<input type="checkbox"/>	Measles _____
<input type="checkbox"/>	<input type="checkbox"/>	Mumps _____
<input type="checkbox"/>	<input type="checkbox"/>	Rubella _____
<input type="checkbox"/>	<input type="checkbox"/>	Polio _____
<input type="checkbox"/>	<input type="checkbox"/>	Chicken pox _____
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A _____
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B _____
<input type="checkbox"/>	<input type="checkbox"/>	Influenza _____
<input type="checkbox"/>	<input type="checkbox"/>	Other (i.e., HIB) _____

Exemption to immunizations claimed.

MEDICATIONS

List all medications currently used. (If additional space is needed, please photocopy this part of the health form.) Inhalers and EpiPen information must be included, even if they are for occasional or emergency use only.

(For more information about immunizations, as well as the immunization exemption form, see Scouting Safely on Scouting.org.)

Medication _____ Strength _____ Frequency _____ Approximate date started _____ Reason for medication _____ _____ Distribution approved by: _____ Parent signature _____ MD/DO, NP, or PA Signature Temporary <input type="checkbox"/> Permanent <input type="checkbox"/>	Medication _____ Strength _____ Frequency _____ Approximate date started _____ Reason for medication _____ _____ Distribution approved by: _____ Parent signature _____ MD/DO, NP, or PA Signature Temporary <input type="checkbox"/> Permanent <input type="checkbox"/>	Medication _____ Strength _____ Frequency _____ Approximate date started _____ Reason for medication _____ _____ Distribution approved by: _____ Parent signature _____ MD/DO, NP, or PA Signature Temporary <input type="checkbox"/> Permanent <input type="checkbox"/>
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NOTE: Be sure to bring medications in the appropriate containers, and make sure that they are NOT expired, including inhalers and EpiPens. You SHOULD NOT STOP taking any maintenance medication.

Emergency contact No.:

Allergies:

DOB:

Last name:

Part C

Informed Consent and Hold Harmless/Release Agreement

I understand that participation in Scouting activities involves a certain degree of risk. I have carefully considered the risk involved and have given consent for myself and/or my child to participate in these activities. I understand that participation in these activities is entirely voluntary and requires participants to abide by applicable rules and standards of conduct. I 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 claims or liability arising out of this participation.

I approve the sharing of the information on this form with BSA volunteers and professionals who need to know of medical situations that might require special consideration for the safe conducting of Scouting activities.

In case of an emergency involving me or my child, I understand that every effort will be made to contact the individual listed as the emergency contact person. 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 to the adult in charge 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, including 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.

- Without restrictions.
- With special considerations or restrictions (list) _____

I hereby assign and grant to the local council and the Boy Scouts of America 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 hereby 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 Boy Scouts of America, and I specifically waive any right to any compensation I may have for any of the foregoing.

- Yes No

Adults authorized to take youth to and from the event: (You must designate at least one adult. Please include a telephone number.)

- 1. _____
- 2. _____
- 3. _____

Adults NOT authorized to take youth to and from the event:

- 1. _____
- 2. _____
- 3. _____

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.


Participant's name _____

Participant's signature _____

Parent/guardian's signature _____
(if under the age of 18)


Date _____

Attach copy of insurance card (front and back) here. If required by your state, use the space provided here for notarization.



BOY SCOUTS OF AMERICA
1325 West Walnut Hill Lane
P.O. Box 152079
Irving, Texas 75015-2079
<http://www.scouting.org>

SKU 34605



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Part C Last name: _____ DOB: _____