



SUANHACKY LODGE # 49 PRESENTS
FALL ORDEAL

October 2- 4, 2009

Alpine Scout Camp – Julie Y CABIN

Name: _____ Phone # _____

Address: _____ City/Town/Zip: _____

Troop # _____ Chapter/ District: _____

Email Address: _____

PLEASE CIRCLE ALL THAT APPLY

Youth (Under 21)

Adult (21+)

ORDEAL

**MEMBERSHIP
 BROTHERHOOD**

VIGIL

___ **ORDEAL & BROTHERHOOD MEMBERS:**

If received by September 30-----\$23.00

If received after September 30 or at door-----\$30.00

___ **ORDEAL CANDIDATES (Additional Cost Covers New Sash)-----\$36.00**

ADULTS: Please fill out the following:

I have experience working with or in the field of: _____ and, I will be able to bring my own tools with me this weekend.

****Please note any dietary restrictions:** _____

Make checks and money orders payable to: Suanhacky Lodge # 49

Send to:

**Suanhacky Lodge #49
 P.O. Box 40417
 Glen Oaks, New York 11004-0417**

CLASS 1 PERSONAL HEALTH AND MEDICAL HISTORY

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

Name _____ D.O.B. _____ Age _____ Sex _____
Name of parent/guardian _____ Phone# _____
Home address _____ City _____
State _____ Zip _____

In the event of an emergency notify:

Name _____ Relationship _____
Telephone _____
Name _____ Relationship _____
Telephone _____
Name of personal physician _____
Telephone _____
Personal health insurance carrier _____ Policy # _____

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

ALLERGIES: Food, medicines, insects, plants: Yes ___ No ___

Explain: _____

GENERAL INFORMATION: Yes or No (Please circle if yes)

ADHD (Attention-Deficit Hyperactivity Disorder) ■ Convulsions/seizures ■ Hemophilia

Asthma ■ Diabetes ■ High blood pressure

Cancer/leukemia ■ Heart trouble ■ Kidney disease

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:

List any physical or behavioral conditions that may affect or limit full participation in 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 _____ Diphtheria _____ Mumps _____

Pertussis _____ Rubella _____

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 or my child (or for me, if participant is an adult).

Date _____ Signature of parent/guardian _____