

2010 GRIZZLY ADVENTURE CAMP
"SAILS AND TALES"
JULY 12-16, 2010 or JULY 19-23, 2010

9:00 A.M. – 3:30 P.M.
CUB WORLD – BEAUMONT SCOUT RESERVATION

RESERVATION APPLICATION – CIRCLE WHICH WEEK

Enclosed is \$80.00 non-refundable reservation fee made payable to:
Greater St. Louis Area Council, BSA

Cub Scout's Name _____

Address _____

City _____ State _____ Zip _____

Telephone Numbers: Home (____) _____ Business: (____) _____

Cell Phone Number (____) _____ Email Address _____

Pack Number _____ District _____ Age _____ Rank _____

_____ **Yes, I want to be an adult helper.** Please send an application. I am physically
able to participate in the program. I can attend day camp on the designated days:
___ Monday through Friday (5 days) ___ Mon ___ Tues ___ Wed ___ Thurs ___ Fri

PARENT SIGNATURE _____

NOTE: Cub Health History on Reverse Must Be Completed

In case of emergency, notify: Name _____

Relationship _____

Address _____

City _____ State _____ Zip _____

Telephone Numbers: Home (____) _____ Business (____) _____

Family Physician's Name _____ Telephone Number (____) _____

NOTE: Boys from the same pack may be placed in different camp dens.

Mail Application and Fee To: Activities Service, Greater St. Louis Area Council, BSA
4568 West Pine Boulevard, St. Louis, MO 63108-2193

CUB SCOUT'S NAME _____ PACK # _____

CUB SCOUT HEALTH HISTORY – GRIZZLY ADVENTURE CAMP

THIS INFORMATION MUST BE COMPLETED AND BE ON FILE IN CAMP FOR A CUB SCOUT TO ATTEND CAMP

HAVE OR SUBJECT TO: (CHECK IF YES)

___ ASTHMA ___ FAINTING SPELLS ___ CONVULSIONS ___ DIABETES ___ HEART TROUBLE

___ EYE-EARS-NOSE-THROAT _____ ALLERGIES TO BEE STINGS OR INSECT BITES

___ OTHER ALLERGIES (medicine, food, pets, etc.) - please list:

If there are any conditions or restrictions we should know about for your son's safety, please describe:

Has your son had any surgery recently (check if yes) ____. If yes, what type of surgery?

Date of surgery

Date of last tetanus booster shot _____

Any conditions now requiring regular medication:

NAME(S) OF MEDICATION(S):

IF YOUR SON IS NOW TAKING MEDICATION, PLEASE SEE THAT IT IS GIVEN TO THE CAMP DIRECTOR EACH MORNING OF CAMP.

MY SON HAS PERMISSION TO SWIM (circle one) YES NO (swimming is limited to 3-5 feet of water)

IF YES, CIRCLE ONE OF THE FOLLOWING:

- my son doesn't know how to swim
- my son is just learning to swim
- my son is an experienced swimmer

PARENT AUTHORIZATION

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed activities except as noted. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the adult leader in charge to secure medical treatment for my son.

I hereby consent to the use of my child's voice and/or photograph in the news coverage, movie making, or similar projects approved by the Boy Scouts of America.

SIGNATURE _____ DATE _____

Parent or Guardian