

Sibling Registration

Orange County Council Cub Scout 2012 Day Camp Pack# _____

- Los Amigos 7/16-20
 El Camino Real 6/25-29
 Orange Frontier 7/23-27
 Portola 7/23-27
 Pacifica 7/9-13 AM
 El Capitan 7/23-27
 Canyons 7/9-13
 Saddleback 6/25-29 AM
 Pacifica 7/9-13 PM
 Rancho Del Mar 7/9-13
 Saddleback 6/25-29 PM

Parents who volunteer to work at Day Camp may register their non Cub Scout children (3-10 years of age and potty trained) in the Sibling Camp which will be held on site during Day Camp hours. **Parents are only allowed to use these child care arrangements while they are working at Day Camp.** Parents must pick up their child at meal times. Siblings are not allowed to accompany parents to the program areas. Youth 11 and older should sign up as youth volunteers - a different form.

First Name _____ **Last Name** _____ **Home Phone** () _____
Mother's Name _____ **Daytime Phone** () _____
Father's Name _____ **Daytime Phone** () _____
Address _____ **Primary Language** _____
City, Zip _____ **Secondary Language** _____
E-Mail _____


In case Parents or Guardians can not be reached, in an emergency who else should be notified? This must be a local person who can pick up the camper if needed.

Name _____ **Relationship** _____ **Daytime Phone** () _____
Name _____ **Relationship** _____ **Daytime Phone** () _____

Please list who **can** pick up your child from day camp. _____

Sibling Camper Information

Sibling Birth Date _____ **Age at Camp** _____ Boy Girl
Days this child will be in Sibling Camp: M T W T F
Days parents will be in camp: M T W T F
Parent working at Camp: _____

I understand that I must pick up my child at the beginning of the meal break and that the sibling camp is closed during that time. I give permission for my child to participate in the sibling camp activities. 


Date: _____ Signature of Adult / Parent / Guardian: _____

<p>Sibling Camp Fees Find out when registration closes for your camp.</p> <p>Do Not mail registrations three weeks before camp. Contact the Camp Director for instructions.</p> <p>So that we can provide each sibling camper with both a T-shirt and a full range of activities we need to charge a small fee for each sibling.</p> <p>Camp Fee - \$5 per day, \$20 maximum + _____</p> <p>Extra T Shirts () at \$5 each + _____</p> <p>Total Due: \$ _____</p>	<p>One Sibling T-Shirt is provided Extra shirts can be ordered on the left</p> <p> <input type="checkbox"/> Youth Small <input type="checkbox"/> Youth Medium <input type="checkbox"/> Youth Large <input type="checkbox"/> Adult Small <input type="checkbox"/> Adult Medium </p>
--	--

California Penal Code Section 12552 Furnishing firearms to Minors under 18 without permission of parent. Every person who furnishes any firearm, air gun or gas operated gun, designed to fire a bullet, pellet, or metal projectile, to any minor under the age of 18 years, without the express or implied permission of the parent or legal guardian of the minor, is guilty of a misdemeanor. I give my permission for the above child to use a firearm as described above.

I give my permission for this child to participate in the following Day Camp Activities at this Day Camp. Not all camps do all of these activities.

Archery: Yes No Signature of Adult / Parent / Guardian: _____
 BB Guns: Yes No Signature of Adult / Parent / Guardian: _____

Minimum age may be required for these activities 

Pictures may be taken of your child or you while at Daycamp for use in promotional publications or on the web site.
To decline participation, please initial here: _____

BSA Health & Medical Record Part A For the person named above To be filled out by parent or guardian annually for all participants

Health/Accident Ins. Carrier _____ Policy # _____

Name of Personal Physician _____ Telephone _____

Medical History - Are you now or have you ever been treated for any of the following, explain:

<p>Y N</p> <p><input type="checkbox"/> Asthma Last attack: _____</p> <p><input type="checkbox"/> Diabetes Last HbA1C: _____</p> <p><input type="checkbox"/> Hypertension (High Blood Pressure)</p> <p><input type="checkbox"/> Heart Disease (i.e., CHF, CAD, MI)</p> <p><input type="checkbox"/> Stroke/TIA</p> <p><input type="checkbox"/> Lung/respiratory disease</p> <p><input type="checkbox"/> Ear/sinus problems</p> <p><input type="checkbox"/> Muscular/skeletal condition</p> <p><input type="checkbox"/> Menstrual problems (women only)</p> <p><input type="checkbox"/> Psychiatric/psychological and emotional difficulties</p> <p><input type="checkbox"/> Behavioral disorders (e.g., ADD, ADHD, Asperger syndrome, autism)</p>	<p>Y N</p> <p><input type="checkbox"/> Bleeding disorders</p> <p><input type="checkbox"/> Fainting spells</p> <p><input type="checkbox"/> Thyroid disease</p> <p><input type="checkbox"/> Kidney disease</p> <p><input type="checkbox"/> Sickle cell disease</p> <p><input type="checkbox"/> Seizures Last seizure: _____</p> <p><input type="checkbox"/> Sleep disorders (i.e., sleep apnea)</p> <p>Use CPAP: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p><input type="checkbox"/> Abdominal/digestive problems</p> <p><input type="checkbox"/> Surgery</p> <p><input type="checkbox"/> Serious injury</p> <p><input type="checkbox"/> Other _____</p>	<p>Allergies or Reaction to: Medication _____ Food, Plants, or Insect Bites _____</p> <p>Medications List all medications currently used. Inhalers and EpiPens must be included. Medication _____ Strength _____ Frequency _____ Date Started _____ Reason _____</p> <p>Immunizations: If had disease, put "D" and year</p> <table border="0"> <tr> <td><input type="checkbox"/> Tetanus _____</td> <td><input type="checkbox"/> Mumps _____</td> <td><input type="checkbox"/> Hepatitis A _____</td> </tr> <tr> <td><input type="checkbox"/> Pertussis _____</td> <td><input type="checkbox"/> Rubella _____</td> <td><input type="checkbox"/> Hepatitis B _____</td> </tr> <tr> <td><input type="checkbox"/> Diphtheria _____</td> <td><input type="checkbox"/> Polio _____</td> <td><input type="checkbox"/> Influenza _____</td> </tr> <tr> <td><input type="checkbox"/> Measles _____</td> <td><input type="checkbox"/> Chicken Pox _____</td> <td><input type="checkbox"/> Other _____</td> </tr> </table> <p><input type="checkbox"/> Exception to immunizations claimed (form required). See Scouting Safely on Scouting.org.</p>	<input type="checkbox"/> Tetanus _____	<input type="checkbox"/> Mumps _____	<input type="checkbox"/> Hepatitis A _____	<input type="checkbox"/> Pertussis _____	<input type="checkbox"/> Rubella _____	<input type="checkbox"/> Hepatitis B _____	<input type="checkbox"/> Diphtheria _____	<input type="checkbox"/> Polio _____	<input type="checkbox"/> Influenza _____	<input type="checkbox"/> Measles _____	<input type="checkbox"/> Chicken Pox _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Tetanus _____	<input type="checkbox"/> Mumps _____	<input type="checkbox"/> Hepatitis A _____												
<input type="checkbox"/> Pertussis _____	<input type="checkbox"/> Rubella _____	<input type="checkbox"/> Hepatitis B _____												
<input type="checkbox"/> Diphtheria _____	<input type="checkbox"/> Polio _____	<input type="checkbox"/> Influenza _____												
<input type="checkbox"/> Measles _____	<input type="checkbox"/> Chicken Pox _____	<input type="checkbox"/> Other _____												

I give my 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 an adult, my spouse or next of kin). In the event I can not 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 me if an adult).

Date: _____ Signature of Adult / Parent / Guardian: _____ 