

# Youth Volunteer Registration

- 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

## Orange County Council Cub Scout 2012 Day Camp

Unit Type and Number \_\_\_\_\_

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_

Scout Rank \_\_\_\_\_ Grade in Fall 2012 \_\_\_\_\_ Age at Camp \_\_\_\_\_ Birth Date \_\_\_\_\_

Mother's Name \_\_\_\_\_ Daytime Phone ( ) \_\_\_\_\_

Father's Name \_\_\_\_\_ Daytime Phone ( ) \_\_\_\_\_

Address \_\_\_\_\_ Primary Language \_\_\_\_\_

City, Zip \_\_\_\_\_ Secondary Language \_\_\_\_\_

E-Mail \_\_\_\_\_ Are you a member of the Order of the Arrow?  Yes  No

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. \_\_\_\_\_

I volunteer for all five days of Day Camp  Yes  No

I will work the following days  M  T  W  T  F

I agree to follow all BSA Standards for Day Camp. I will be at camp on the days indicated and I understand that my Day Camp assignment may be rotated. I will volunteer in all camp areas to the best of my ability and attend any required training sessions.

Date: \_\_\_\_\_ Signature of Youth Volunteer: \_\_\_\_\_



### Youth Information

Find out when registration closes for your camp.

**Do Not** mail registrations three weeks before camp. Contact the Camp Director for instructions.

What special accommodations are needed for you to perform tasks at Day Camp?

Have you worked with children in a group situation?  Yes  No

Have you previously worked at a Cub Scout Day Camp?  Yes  No

Where would you like to work at Day Camp? \_\_\_\_\_

Extra T Shirts ( ) at \$10 each \_\_\_\_\_  \$ \_\_\_\_\_

Youth who Volunteer 3-5 days will receive one camp shirt  
Extra shirts can be ordered on the left

- Adult Small
- Adult Medium
- Adult Large
- Adult XL
- Adult 2XL

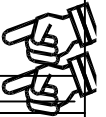
### California Penal Code Section 12552

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: \_\_\_\_\_



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><b>Y N</b></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><b>Y N</b></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> |
|--|--|

Allergies or Reaction to: Medication \_\_\_\_\_  
Food, Plants, or Insect Bites \_\_\_\_\_

Medications List all medications currently used. Inhalers and EpiPens must be included.  
Medication \_\_\_\_\_ Strength \_\_\_\_\_ Frequency \_\_\_\_\_  
Date Started \_\_\_\_\_ Reason \_\_\_\_\_

Immunizations: If had disease, put "D" and year

<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 _____

Exception to immunizations claimed (form required). See Scouting Safely on Scouting.org.

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: \_\_\_\_\_

