Cho-Gun-Mun-A-Nock Lodge #467 - Brotherhood **Fall Conclave Registration** **September 10-12, 2010** **Howard H. Cherry Scout Reservation** **Registration starts 6:00 pm Friday**	**Lodge Use Only** Date Recd ____________ Receipt # _____________ By ____________________ Beads Given ___________ Computer Entry _________

Registration fee of $30.00 and this COMPLETED form must be received at the Scout Shop
(660 32nd Avenue SW, Cedar Rapids, Iowa 52404)
before close of business on Friday September 3, 2010 to avoid late fee of $5.00.

Amount Enclosed:
Brotherhood Fee (Including Registration) ($30) $_______
(After 09/03/2010 - ADD $5) $_______
(Please circle the year) 2010 or 2011 Dues ($12) $_______

Total Enclosed
$ ________

Note: This form should ONLY be used by Ordeal members who are completing their Brotherhood, will be submitting their Brotherhood Application, and are participating in the Brotherhood Ceremony at this Conclave.

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OA Event Medical Form

Name ___________________________________ Date of Birth _______________ Age __________

Address ____ City ______________________

Phone __________________________ Troop/Crew ________________ Chapter RC / 3R / OCV

Email Address ____

Please circle which meals you will be eating at this event:

Friday Cracker Barrel Saturday Breakfast Saturday Lunch Saturday Supper Sunday Breakfast

Parent/Guardian/Spouse Name ____

Home Phone _____________ Work Phone _____________ Cell Phone _____________

Emergency Contact Name (other than above) ____

Home Phone _____________ Work Phone _____________ Cell Phone _____________

IMPORTANT!

I give permission for full participation in this OA Lodge event, subject to limitations noted on the reverse side of this form. 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 that I can not be reached, I hereby give permission to a licensed health-care practitioner, selected by an adult leader in charge, to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication(s) for my child (or me, if participant is an adult)

The signature below implies consent for the use of this Scout's name and picture in future publicity.

Signature ____ Date __________________

(Complete reverse side)

Additional Emergency Contact (other than parent) ____

Home Phone _____________ Work Phone _____________ Cell Phone _____________

Additional Emergency Contact (other than parent) ____

Home Phone _____________ Work Phone _____________ Cell Phone _____________

This section MUST be completed if your son will be leaving and returning to the OA event.

I give permission for my son to leave this event at ____:____ AM/PM on __________________, 2010 to attend ____. He will return to the OA event at approximately ____:____ AM/PM on _______________________, 2010.

Signature of Parent/Guardian ____________________________________ Date ________________

Class 1 Personal Health History

HEALTH HISTORY: Please check all items, **past or present**, to your health history. Explain any "yes" answers.

ALLERGIES (food, medicines, insects, plants) Yes No Explain: ___________________________

GENERAL INFORMATION:

	Yes	No		Yes	No		Yes	No
ADHD (Attention-Deficit Hyperactivity Disorder)			Convulsions/Seizures			Hemophilia		
Asthma			High Blood Pressure			Diabetes		
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, including drug, dosage, route (oral, injection, etc.), and frequency: ____

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List any physical or behavioral conditions that may affect or limit full participation in swimming, backpacking, hiking long distances, or playing strenuous physical games: ______________________

____

List equipment needed such as wheelchair, braces, glasses, contact lenses, etc.:_________________

IMMUNIZATIONS: Please indicate date of last inoculation.

Tetanus toxoid ____________________ Measles ____________________ Polio ____________________

OR DPT ____________________ OR MMR ____________________ ____________________

Hepatitis A ____________________ Varicella ____________________ OR Chicken pox ________________

Hepatitis B ____________________

PHYSICIAN/INSURANCE INFORMATION: Please note that all participants must have accident insurance coverage.

Name of personal physician: ___________________________________ Telephone No: ____________________

Personal health/accident insurance carrier: _________________________ Policy No: ______________________