

Cho-Gun-Mun-A-Nock Lodge #467 - Ordeal
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 \$35.00 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:

Ordeal Fee (Including Registration) (\$35) \$ _____
(After 09/03/2010 - ADD \$5) \$ _____

<p>Total Enclosed \$ _____</p>
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Note: This form should ONLY be used for Ordeal Candidates who are completing their Ordeal.

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)	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>

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: _____

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: _____