

SR-7A 2009 CONCLAVE

Hosted by Wahunsenakah Lodge

April 24-26, 2009

Bayport Scout Reservation

Individual Registration & Preorder Form

Deadlines:
Preorders 01/31/09
Registration (no late fee): 03/06/09
Registration Cutoff: 03/31/09

Mail To: Shenandoah Lodge 258
 Stonewall Jackson Area Council
 PO Box 813
 Waynesboro, VA 22980

Complete **ALL** Information: Please print or type.

Last Name: _____ First Name & MI: _____

Address: _____ Lodge: _____

City, State, zip: _____ Date of Birth _____

Telephone # _____ Honor (circle One) O B V

Cell Phone # _____ Unit _____ Email: _____

Name (as you wish it to appear on your nametag) _____

FEES:

Conclave fee (if paid by 03/06/09.) **\$35.00**
 Late Fee (if you registered after 3/6/09): \$15 _____

Preorder Items	Number Ordered	Cost	Total Cost
Conclave Participant patch		\$5.00 each =	
Conclave Backpatch		\$12.00 each =	
Conclave Hat Pin		\$4.00 each =	
Conclave Neckerchief		\$10.00 each =	
Conclave T-shirt-(M, L, XL) Size _____		\$15.00 each =	
Conclave T-shirt-(XXL, XXXL) Size _____		\$17.00 each =	
Conclave Polo Shirt-(M, L, XL) Size _____		\$25.00 each =	
Conclave Polo Shirt-(XXL, XXXL) Size _____		\$27.00 each =	
Conclave Hat		\$15.00 each =	
Conclave Hoodie (M, L, XL) Size _____		\$26.00 each =	
Conclave Hoodie (XXL, XXXL) Size _____		\$28.00 each =	
Conclave Wicking Tee- (M, L, XL) Size _____		\$24.00 each =	
Conclave Wicking Tee- (XX L,XXXL)		\$26.00 each =	
SR-7A Decal		\$3.00 each =	
PREORDER GRAND TOTAL:			

SPECIAL NEEDS:

Any Arrowman that will require special needs at Conclave (i.e. Diet, Accommodations, Routine Medication, Transportation, etc), please check box at right and explain below or on back:

Personal Health History

To be filled out by parent, guardian, or adult participant. Please print in ink.

Identification:

Name _____ Date of Birth _____ Age _____ Sex _____

Name of parent or guardian _____ Telephone _____

Home address _____ City _____ State _____ Zip _____

If person named above is not available in the event of an emergency, notify

Name _____ Relationship _____ Telephone _____

Name _____ Relationship _____ Telephone _____

Name of personal physician _____ Telephone _____

Personal health/accident insurance carrier _____ Policy No. _____

Check all that apply, 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"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<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: _____

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: (Give date of last inoculation)

Tetanus toxoid _____ Measles _____ Polio _____

Diphtheria _____ Mumps _____

Pertussis _____ Rubella _____

I give permission for full participation in BSA programs, subject to limitations noted herein.

In case of emergency, I understand that every effort will be made to contact me (if participant is an adult, my spouse or next of kin). In the event I cannot 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 for me, if participant is an adult).

Date _____ Signature of parent/guardian or adult _____