**Lsnider@staffingplusinc.com**

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| **CONTACT INFORMATION** |
| **Last Name:** |  | **First Name:** |  | **Home Phone:** |  | **Cell Phone:** |  |
| **Unit Type:** | **Troop** |  | **Crew** |  | **Unit Number:** |  | **District:** |  | **Council:** |  |
| **Street Address** |  | **City:** |  | **State:** |  | **Zip Code:** |  |
| **E-mail address:** |  | **Date of Birth:** |  | **Gender:** | **Male** |  | **Gender:** | **Female** |  |
| **EMERGENCY CONTACT INFORMATION** |
| **Last Name:** |  | **First Name:** |  | **Relationship:** |  |
| **Home Phone:** |  | **Cell Phone:** |  | **Work Phone:** |  |

**All participants must submit a complete BSA health form, Parts A, B, and C. All health forms must be on file with Okpik by November 13, 2015. All health forms must be good through February 1, 2016. Deposit of $20 is due by Friday October 16, 2015 to guarantee your position. Payment in full of $100 is due by Friday November 13, 2015.**

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| **REQUIRED FOR YOUTH ONLY** |
| **Scoutmaster Name:** |  | **Phone Number:** |  |
| **Scoutmaster Signature** |  | **Scoutmaster Email:** |  |
| **Regulations require that adult counselors must be present during the entire Scout activity. Signature is required at the X's.**  |
| **My child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ has my permission to attend the: 2015-2016 Okpik Cold-Weather Campout. I am familiar with the details of this activity. I will be certain that my child does not go if he or she is not in good physical condition and good health. In consideration of the services donated by others, I will hold free from all liability, in case of accident or illness, course volunteers, Blackhawk Area Council and the BSA. I further understand and agree that any serious infraction(s) of camp rules by my child could result in dismissal from the aforementioned activity. Return transportation under such circumstances will be my responsibility.** |
| **PARENT CONTACT INFORMATION** |
| **Parents Name:** |  | **Relationship:** |  |
| **Home Phone:** |  | **Cell Phone:** |  | **Work Phone:** |  |
| **TO WHOM IT MAY CONCERN:****As a parent and/or guardian, I do herewith authorize the treatment by a qualified and licensed medical doctor of the following minor in the event of a medical emergency which, in the opinion of the attending physician, may endanger his or her life, cause disfigurement, physical impairment or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me.****Date or dates when release is intended, February 1, 2015. This release form is completed and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstances in my absence:** |
| **Parent or Guardian Name:** |  | **Signature (X):** |  |
| **Relationship:** |  | **Date:** |  |
| **Street Address** |  | **City:** |  | **State:** |  | **Zip Code:** |  |
| **Child’s Physician’s Name:** |  | **Phone Number:** |  |