CAMP TOMAHAWK
Cub Scout Day Camp
The Capitol District, Baltimore Area Council

Attach Participant Photo Here

2008 ADULT APPLICATION

PACK _________

Name: ____________________

Address: ____________________

City/State/Zip: ____________________

E-mail

Phone (h) (w) (cell)

Volunteer Commitment

Position at Camp ☐ Single Day Vol. ☐ Multi-day Vol. ☐ All Wk DL ☐ Admin ☐ Station Staff ☐ Set-up/Tear-down

Days Attending ☐ Saturday set-up ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Friday tear-down ☐ Sat tear-down

Number of years attending camp as all week volunteer:____________________

List names of related campers, Tag-a-longs, adults, and youth aides attending Camp:

____

- ☐ Currently a Registered Scouter as _______________(Position)
  For ________________ (Pack/District/Council)
- ☐ Eagle Scout
- ☐ Attended Cub Scout Leader Basic Training
- ☐ Attended Youth Protection (Date:____________________)
- ☐ Attended Cub Scout Day Camp Training (Sections:______________, Expires: ______)

Medical or Specialized Training

☐ None
☐ EMT ☐ RN ☐ LPN ☐ MD ☐ Other ____________________
☐ CPR ☐ First Aid ☐ Life Saving ☐ Other ____________________

Emergency Contact Information

Name: ____________________ Relationship: ____________________ Phone: ____________________

I understand that by registering for the days stated above, I am committing to be present at Day Camp for the entire program time on those days. If, for any reason, I cannot fulfill my commitment, I will notify the Camp Director(s) immediately.

Please complete required Personal Health/Medical Record on page 2.

Registration is not complete without both pages of registration form!!!!!

NOTE: PACKS MUST PROVIDE AT LEAST ONE ALL WEEK ADULT VOLUNTEER PER 6 REGISTERED CAMPERS.

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Name: ______________________________ Nickname: ______________________________

Adult is currently registered with Pack # _________ Den # ____________

ALLERGIES TO ☐ FOOD ☐ MEDICINES ☐ INSECTS ☐ PLANTS ☐ OTHER (i.e. latex)

DESCRIBE ____

GENERAL HEALTH INFORMATION

☐ ADHD/ADD ☐ Asthma ☐ Diabetes ☐ High Blood Pressure ☐ Cancer/Leukemia
☐ Heart Problems ☐ Kidney Disease ☐ Convulsions/Seizures ☐ Hemophilia
☐ Other serious problems

Explanation ____

List any medications to be taken at camp: ____

List any physical or behavioral conditions that may affect or limit full participation in hiking long distances or playing strenuous physical activities: ____

List any equipment needed at camp including glasses or contact lenses, wheelchair, braces, and retainers: ____

Immunization Dates Tetanus_______________

Emergency Contact Information (other than parent)

Name: ________________________ Relationship: ___________________ Phone: ___________________

Personal Physician

Name: ________________________ Phone: ___________________

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 that I (or spouse or next of kin) cannot be reached, I hereby give my permission to the physician or facility selected by the adult Scout leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child (for me, if an adult).

I also give permission for the camp Medical Staff to administer the following over the counter medications if it is deemed necessary.

_____Tylenol ____Benedryl _____ Advil

Signature ______________________________ **Date**___________________

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