

Fall 2009 SERVICE WEEKEND APPLICATION
October 23-25, 2009 - Schiff Scout Reservation, Wading River, Long Island

Name _____ Phone _____ District _____

Address _____ Troop # _____

Town _____ State _____ Zip _____

Email Address _____ @ _____

Ordeal Candidate (\$50.00)

Brotherhood Candidate (\$34.00)

Brotherhood Candidate - Friday Only – No Meals (\$14.00)

Brotherhood Sponsor's Name _____

Contact your Chapter Adviser with questions regarding Brotherhood

Ordeal, Brotherhood, and Vigil Members (\$20.00)

Day Trip (\$15.00) Saturday only- includes 3 meals- for members only- **no candidates**

Elangomat (\$Free\$) For members only- **no candidates** - Must arrive on Friday

Special Food – A note stating restrictions must accompany this form and be received by the council office by **October 16, 2009**

I am over - under 21 year of age (if under, state age) _____

(circle one)

Please enclose a check for the appropriate amount, makes check payable and mail to:

Theodore Roosevelt Council, BSA; 544 Broadway; Massapequa, NY 11758-5010

PLEASE NOTE: It is the Lodge and Council policy that anyone (youth or adult) leaving a Lodge event (work weekend, etc) **MUST SIGN OUT** at Hickox Dining Hall before leaving camp and sign in again upon return.

Any youth (under 18 years of age) must have parental permission in writing in order to be able to leave camp before the event is scheduled to be over. This permission must be presented to the lodge adviser upon arrival at camp. This written permission must include time and date of departure, and date and time of return, who the youth will be traveling with. This must be signed and dated by the youth's parent or guardian.

The Theodore Roosevelt Council, BSA standard refund policy is in effect for this activity.

In compliance with the Americans with Disabilities Act, Buckskin Lodge, Order of the Arrow, WWW will make all reasonable efforts to accommodate persons with disabilities at their activities. Please call the council service center (516-797-7600) with your request.

CLASS 1 PERSONAL HEALTH AND MEDICAL HISTORY

To be filled out by parent or guardian:

Please print in INK

Name _____ Date of Birth _____ Age _____ Sex _____

Name of Parent of Guardian _____ Telephone _____

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

Name _____ Relationship _____ Telephone _____

Name of personal physician _____ Telephone _____

PARENTAL STATEMENT: To the best of my knowledge, this information is accurate and complete, I the undersigned parent of above named minor, do hereby authorize the adult leadership, as my agent(s) to consent to any diagnostic procedures or medical care which is deemed advisable by, and is to be rendered under the general or special supervision of any licensed physician and/or surgeon at 1) John T. Mather Memorial Hospital, Port Jefferson, New York; 2) Saint Charles Hospital, Port Jefferson, New York; 3) Central Suffolk Hospital, Riverhead, New York; or 4) University Medical Center, State University of New York at Stony Brook, Stony Brook, New York, when such diagnosis or treatment is rendered at said hospital or in doctor's offices. It is understood that this authorization is given in advance of any specific need for treatment but is given to provide authority on the part of the aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital/office care which the physician in the exercise of his or her best judgement may deem advisable. This authorization shall remain in effect until one year after the signed date below, unless sooner we deliver to said agent(s).

Date _____ Signature of parent/guardian or adult _____

Check all items that apply past or present, to you son's health history. Explain any "yes" answers.

Asthma	<input type="checkbox"/> YES <input type="checkbox"/> NO	Heart trouble	<input type="checkbox"/> YES <input type="checkbox"/> NO	Leukemia	<input type="checkbox"/> YES <input type="checkbox"/> NO
Allergies	<input type="checkbox"/> YES <input type="checkbox"/> NO	Hi Blood Prsre	<input type="checkbox"/> YES <input type="checkbox"/> NO	Cancer	<input type="checkbox"/> YES <input type="checkbox"/> NO
Convulsions	<input type="checkbox"/> YES <input type="checkbox"/> NO	Diabetes	<input type="checkbox"/> YES <input type="checkbox"/> NO	Hemophilia	<input type="checkbox"/> YES <input type="checkbox"/> NO

EXPLAIN: _____

Immunizations:	Date of Inoculation	Date of Inoculation	Date of Inoculation
Tetanus toxic	_____	Polio _____	Mumps _____
Diphtheria	_____	Pertussis _____	Measles _____
			Rubella _____

