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OA General

Wa-La-Moot-Kin Lodge 336  
Blue Mountain Council BSA  
8478 W. Gage Boulevard  
Kennewick, WA 99336



# Spring/Fall Ordeal Registration

Please Print Clearly

Ordeal/Brotherhood/Vigil (Circle Current Membership)

Event Date (circle): May 15-17, 2009 or Aug 21-23, 2009

Name \_\_\_\_\_ E-Mail Address \_\_\_\_\_ Phone Number \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Date of Birth (MM/DD/YEAR) \_\_\_\_\_ Type of unit/Troop/Team Etc. \_\_\_\_\_ Unit Number \_\_\_\_\_ Position in Unit \_\_\_\_\_ Scout Net ID# from ID Card \_\_\_\_\_

Total Amounts Enclosed: (\$15/20 to attend) \_\_\_\_\_ Annual Dues (\$15/yr) \_\_\_\_\_

**The Health History Form Below is REQUIRED for Event Participation**

Health/Accident Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_

**Check if you have you had or are you subject to:**

- |  |  |
|--|--|
| <input type="checkbox"/> Asthma        | <input type="checkbox"/> Bleeding Disorders                            |
| <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Food Allergies (List restrictions below)      |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Fainting Spells                               |
| <input type="checkbox"/> Convulsions   | <input type="checkbox"/> Other Allergic Reactions (Stings/plants/etc.) |

Are you currently taking any medication? \_\_\_\_\_  
If yes for what? \_\_\_\_\_ How often do you take the medication? \_\_\_\_\_

**Immunization Dates**

Tetanus: \_\_\_\_\_ Polio: \_\_\_\_\_ Mumps: \_\_\_\_\_ Pertussis: \_\_\_\_\_  
Diphtheria: \_\_\_\_\_ Measles: \_\_\_\_\_ Rubella: \_\_\_\_\_

**Do you have difficulty with** (check if yes):

Bed wetting \_\_\_\_\_ Digestion \_\_\_\_\_ Sleepwalking \_\_\_\_\_ Nose bleeds \_\_\_\_\_

Please list any activities this individual should be restricted from participating in? \_\_\_\_\_

Please list any special dietary needs. \_\_\_\_\_

**Medical Release and Authorization**

This health history is accurate as far as I know, and the person herein described has permission to engage in all prescribed activities, except as noted above. In the event I cannot be reached in an emergency I hereby give my permission to the physician selected by the adult leader in charge to hospitalize, secure proper anesthesia, or order injections.

Participant Signature \_\_\_\_\_ Parent/Guardian Signature \_\_\_\_\_

( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
Home Phone Business or Emergency Contact Phone Date

**Return this completed form and \$15 for the activity and \$15 for dues to the above address no later than three weeks before event date. After that, event fee is \$20.**