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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.