West Central Florida Council
Boy Scouts of America
Cub Scout Day Camp 2008, Blast from the Past

ADULT VOLUNTEER APPLICATION

Calusa: ____ June 9 – 13th, 9:00am – 4:30pm **Twin Rivers: ____ June 16th – 20th, 9:00am – 4:00pm**
____ June 16th – 20th 9:00am – 4:30pm (joint with Skyway)

Skyway: ____ June 16th – 20th, 9:00am – 4:30pm (joint with Calusa) **Osceola: ____ June 23rd – 27th, 9:00am – 4:30pm**

NAME: _____
(first name) (middle name) (last name)

ADDRESS: _____City_____ State_____ Zip_____

PHONE #_____ EMERGENCY #_____
CELL PHONE: _____ E-MAIL: _____
PACK or TROOP Affiliation_____ Position_____

NAME of SCOUT(s) attending Day Camp _____

FULL TIME (full week) volunteers receive one Camp T-shirt. *Please select the size*:
ADULT SM._____ MED._____ LG._____ X-LG._____ XX-LG._____ XXX-LG. _____
If you are a part time volunteer or would like additional shirts at $10.00 each, please indicate
(XXL & XXXL @ $12.00): # Shirts _____X $10.00 ($12.00) =_____.
*Please indicate if you are **PART-TIME** (mark days attending)*: M___ T___ W___ Th___ F___

TOT LOT CHILDREN attending camp:
NAME: _____AGE: _____
NAME: _____AGE: _____

Please complete Adult Emergency Information Form on back

MEDICAL INFORMATION: Have or Subject to the following: (check if yes)
Asthma ___Fainting Spells___ Convulsions___ Diabetes___ Heart Trouble___ Prosthesis___ Migraine Headaches___
Bleeding Disorders___ Ear Infections or Aches___ Stomach Problems___ and/or Other_____
ALLERGIES to food, medicine, plant, animal, insect, other_____
MEDICAL CONDITIONS requiring care, medication or diet_____
MEDICATIONS currently being taken and dosage_____
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*I am at least 21 years of age and agree to volunteer my time to help staff Cub Scout Day Camp. **I am aware that my placement on staff is to be decided by the Camp Directors.** I am aware that I will not receive payment for this position. I also agree to attend the STAFF TRAINING SESSION and to follow the policies of BSA and those outlined at the training. I am aware that I MUST have a current Youth Protection Card and agree to if necessary attend the Youth Protection Course. I understand that I will be under the direction of the Camp Directors at all times during camp.*

I hereby assign and grant to the boy Scouts of America the right and permission to use and publish the photography/film/video tapes/electronic representations and/or sound recordings made during my visit to the WCFC Cub Scout Day Camp 2008, Blast from the Past, and I hereby release the Boy Scouts of America from any and all liability from such use and publication.

Signature_____ Date_____

MANDATORY *Training Session dates for camp staff in all Districts:*
Saturday, Mar 3rd, 2-4pm at Camp Soule for Calusa, Osceola and Skyway
Thursday, May 15th, 7pm-9pm at Camp Soule for Calusa, Osceola and Skyway
Saturday, June 7th, 9am -1pm at First United Methodist Church (9025 49th Street N, Pinellas Park)
for **Calusa-week two only**, Osceola and Skyway
Saturday, June 7th, 9am -3pm at Griffith Park Civic Association 9100 Flint, New Port Richey for Twin Rivers

------Please Note Attendance at ONE of the Training Sessions Is Required To Work Camp------

Youth protection is available online at www.wcfcbsa.org and is required for all adults.
Safe Swim Defense is also available online at www.wcfcbsa.org and is required for adults volunteering at Camp Soule

EMERGENCY INFORMATION- Adult

Name_____ Age_____ Pack/Troop_____ District_____

Address_____ City/Town_____ ZIP _____

In Case of Emergency, Notify (please provide two emergency contacts:

① Name_____ Relationship_____

Address_____ City State

Phone (H) (W) (C) _____

② Name_____ Relationship_____

Address_____ City State

Phone (H)_____ (W)_____(C)_____

Family Physician_____ Phone_____

Health History:

Have or subject (check if yes, describe any checked items):

_____Asthma (is inhaler needed?) _____Fainting Spells _____Convulsions _____Heart Trouble

_____Diabetes _____Sports Restrictions (specify)_____

_____Allergy or reaction to any medication, food, insect, or other (specify)_____

Have difficulty with (check if yes): _____Eyes _____Ears _____Nose _____Throat _____Lungs _____Digestion

Any condition requiring medication?_____

Name of medication_____

Medication must be in original pharmacy container and must be turned in to Camp First Aid Staff.

Any restrictions on activity for medical reason?_____

Be sure that you fill out the history in full. If you have any condition that warrants regular physician's attention or any restrictions on activity, please have your doctor review and sign; otherwise a physician's signature is not required. This health history is correct so far as I know. I can engage in all prescribed activities, except as noted above by me and/or the physician.

Authorization for Medical and Dental Treatment:

I _____ the undersigned who resides at the address set forth below, hereby authorize any of the adult leaders at Cub Scout Day Camp, West Central Florida Council, BSA, to procure and authorize any x-ray examination, anesthetic, hospitalization, injection, medications, surgery or other medical treatment for me, as in the judgement of the adult leader, the emergency situation may warrant to be rendered under the general or specific supervision and on the advice of any physician or surgeon licensed to practice in the State of Florida, and consent to any x-ray examination, anesthetic, dental or surgical diagnosis or treatment, and hospital care, to be rendered by any dentist licensed to practice in the State of Florida. No adult leader incurs any financial responsibility to himself.

SIGNATURE_____

Address_____ City/Town_____ ZIP

Emergency Phone Numbers (H)_____ (W)_____

I am insured by (Name of Insurance Company)_____

Group Number_____Policy Number_____

This completed form must be on file all week while in attendance. You may not participate if this form is not on file or incomplete.