

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

YOUTH VOLUNTEER APPLICATION

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

Twin Rivers: ____ June 16th – 20th, 9:00am – 4:00pm

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

Osceola: ____ June 23rd – 27th, 9:00am – 4:30pm

Please fill out completely and return with the Youth Emergency Information form on the back to the council service center.

Please PRINT or TYPE:

Name _____ Troop _____

Street Address _____ District _____

City, State, Zip _____ Age _____

Home Phone _____ Cell Phone _____ Grade as of September, 2008 _____

Emergency Contact Name _____

Emergency Contact Phone Number _____

Parent's Name _____

Parent's Phone (Home) _____ (Work) _____ (Cell) _____

Boy Scout/Youth Rank _____ Position (If any in Troop) _____

T-shirt Size Adult: S _____ M _____ L _____ XL _____ XXL _____ XXXL _____

*Please note each full time Youth Volunteer will receive (1) free Staff T- Shirt for the week that they work. Due to how dirty we can get at camp, it is suggested that you may wish to buy an additional shirt.

All Youth Staff must be wearing a Staff Camp Shirt to work in Camp.

_____ Extra T-shirt (size) _____ @ \$10.00 ea (\$12.00 for XXL & XXXL) = _____

My son has permission to attend Cub Scout Day Camp as a Boy Scout/Youth staff member. If the youth is 14 years or younger, they may be assigned as a den chief.

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 child's 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.

Parent or Guardian

I recommend this Boy Scout/Youth as a staff member for Cub Scout Day Camp. In my opinion, he/she has the maturity necessary to be a good example to the Cub Scouts at camp

Scoutmaster

I volunteer to be a staff member this summer at Cub Scout Day Camp. I promise that I will uphold the ideals of Scouting while at Day Camp, as stated in the Scout Oath, Law, and Motto.

Boy Scout

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-----

EMERGENCY INFORMATION- Youth

Name _____ Age _____ Pack/Troop _____ District _____
Address _____ City/Town _____ ZIP _____

☐ Name _____ Relationship _____
Address _____ Phone (H) _____ (W) _____ (C) _____
☐ Name _____ Relationship _____
Address _____ Phone (H) _____ (W) _____ (C) _____
Family Physician _____ Phone _____

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(s) _____

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

Medications to be dispensed at camp

Any restrictions on activity for medical reason? _____

BE SURE THAT YOU, THE PARENT, FILL OUT THE HISTORY IN FULL. IF YOUR SON HAS 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 and the person herein described has my permission to engage in all prescribed activities, except as noted above by me and/or the physician.

I/We, the undersigned parent(s) or guardian having legal custody of Scout _____
a minor, age _____, who resides with me/us 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 the above Scout as, in the judgement of the adult, 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 to the minor by any dentist licensed to practice in the State of Florida. No adult leader incurs any financial responsibility to himself.

SIGNATURE(S) OF PARENT(S) OR LEGAL GUARDIAN

Father _____ Mother _____ Legal Guardian _____

Address _____ City/Town _____ ZIP _____

Emergency Phone Numbers (H) _____ (W) _____ (C) _____

The above named child is insured by (Name of Insurance Company) _____

Group Number _____ Policy Number _____

Physician's signature required only for those boys with activity restrictions or conditions that warrant regular Physician's attention or medication.

Physician's Signature _____ Date _____
Physician licensed to practice medicine in Florida

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