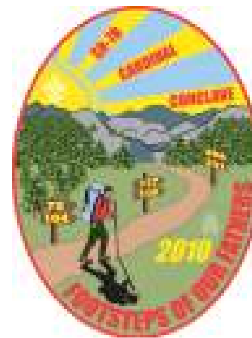
Out of Section Guest Registration Form



Due Date:
April 1, 2010

Please include:
A $30 check payable to:
East Carolina Council

Return to:
Phil Decker
2499 Irvin Dr.
Kinston, NC 28504
pdecker@suddenlink.net

Medical form:
Bring Conclave Medical Form with you to Conclave.

Guest Information

Name: ______________________

Address: ______________________

City State & Zip: ______________________

Telephone: ______________________

Email: ______________________

Date of Birth: ______________________

Chapter: ______________________

Lodge Name: ______________________

Ordeal / Brotherhood / Vigil: ______________________

Dietary Needs: ______________________

Emergency Contact:

Name: ______________________

Relationship: ______________________

Day Telephone: ______________________

Evening Telephone: ______________________

Photo release statement	
I hereby give the Section permission to use any photos in which I appear that are taken at Conclave for use in promoting future events.	
Signature:	**Date:**

Form 5b

Delegate Medical Form Lodge #_____

To be filled out by parent/guardian or adult participant. Please print in ink.		
Delegate Information		
Name:	**Email:**	
Address:		
City	**State:**	**Zip Code:**
Phone: ( )	**Date of Birth:**	
Circle One: Ordeal Brotherhood Vigil		
Primary Emergency Contact		
Name:	**Relationship:**	
Day Phone: ( )	**Evening Phone: ( )**	
Secondary Emergency Contact		
Name:	**Relationship:**	
Day Phone: ( )	**Evening Phone: ( )**	
Medical Information		
Do you: ____ have any medical restrictions? ____ currently take any medications? ____ have any dietary restrictions?	**Explain:**	
Health Insurance Company:	**Policy #:**	
Have or subject to: __Convulsions __Asthma __ Fainting Spells __Bleeding disorder __Diabetes __ Heart Trouble __Allergy to medication, food, plant, animal, or insect __A condition requires special care, medication or diet __NONE OF THE ABOVE APPLY ___ Other	**Explain:**	
__Any condition now requiring regular medication?	**Name of medication:**	
Last Tetanus toxiod date:		
I give my permission for full participation in BSA programs, subject to limitations noted herein. In the event of illness or accident in the course of such activity, I request that measures be instituted without delay as the judgment of medical personnel dictates. **In case of emergency**, I understand every effort will be made to contact me (an adult, my spouse or next of kin). In the event, I cannot be reached, I hereby give my permission to the physician selected by the adult leader in charge to secure proper treatment, including but not limited to hospitalization, anesthesia, surgery, or injections of medications for my child (or for me, if an adult)		
Participant	**Parent or Guardian**	
Signature: **Date:**__________	**Signature (if participant under 18 years):** **Date:**__________	

Form 2b