Ranachqua Lodge #4
Order of the Arrow
GNYC - The Bronx

2009 SPRING ORDEAL-BROTHERHOOD WEEKEND

APRIL 17 - 19, 2009

PLACE: ALPINE SCOUT CAMP; ALPINE, NJ

CHECK-IN: FRIDAY, 8:00 PM – KEPHART & POWELL

PICK-UP: SUNDAY, APRIL 19, 2009 – 11:00 AM

NAME: _____

ADDRESS: _____

CITY: _____STATE:_____ ZIP: _____

E-MAIL: _____UNIT: _____

PHONE: _____ DOB: _____

PID NUMBER: _____

(THE PID IS YOUR PERSONAL IDENTIFICATION NUMBER ON SCOUTNET. IT IS THE LONG NUMBER ON YOUR BSA REGISTRATION CARD)

I AM ATTENDING AS (PLEASE CHECK):

	POST MARKED BY 4/03/09	AFTER 4/03/09
_____ ORDEAL CANDIDATE	$50.00_____	.....$65.00_____
_____ BROTHERHOOD CANDIDATE.....	$35.00_____	.....$45.00_____
_____ BROTHER DOING SERVICE ,.....	$20.00_____	.....$20.00_____

DEADLINE IS APRIL 3, 2009

*******NO EXCEPTIONS*******

ORDEAL CANDIDATE'S FEE INCLUDES LODGE DUES, OA SASH, RANACHQUA FLAP PATCH, FOOD AND THE ORDER OF THE ARROW HANDBOOK.

BROTHERHOOD CANDIDATE'S FEE INCLUDES THE BROTHERHOOD SASH AND FOOD.

ORDEAL CANDIDATES SHOULD BE PREPARED TO SLEEP UNDER THE STARS FRIDAY NIGHT.

PLEASE SPECIFY IF YOU HAVE SPECIAL DIETARY NEEDS.

PAYMENT AND THE ATTACHED BSA CLASS 1 MEDICAL MUST ACCOMPANY THIS APPLICATION.

LIMITED SUBSIDIES ARE AVAILABLE, ON A CASE BY CASE BASIS, TO THOSE WHO CANNOT AFFORD THE ORDEAL. PLEASE CONSULT YOUR UNIT LEADER OR THE LODGE ADVISOR, EDNA ACQUAFREDDA AT (718) 548-0193 (E-MAIL EDBANKER1@AOL.COM)

MAIL THIS APPLICATION ALONG WITH PAYMENT TO:

RANACHQUA LODGE #4;
C/O MRS. EDNA ACQUAFREDDA
3635 JOHNSON AVE APT 1H
BRONX, NY 10463

Make check payable to GNYC – BSA. Write Ranachqua Lodge in Memo.

PERSONAL HEALTH AND MEDICAL RECORD

Class 1 (update annually for all participants). Activity: Day camp, overnight hike, or other programs not exceeding 72 hours, with level of activity similar to that of home or school. Medical care is readily available. Current personal health and medical summary (history) is attested by parents to be accurate. This form is filled out by all participants and is on file for easy reference.

CLASS 1 PERSONAL HEALTH AND MEDICAL HISTORY

(To be filled out annually by all participants)

To be filled out by parent, guardian, or adult participant. Please print in ink.

IDENTIFICATION

Name_____ Date of birth_____ Age_____ Sex_____

Name of parent or guardian_____ Telephone_____

Home address_____ City_____ State_____ Zip_____

Business address _____ City_____ State_____ Zip_____

If person named above is not available in the event of an emergency, notify

Name_____ Relationship_____ Telephone_____

Name_____ Relationship_____ Telephone_____

Name of personal physician _____ Telephone_____

Personal health/accident insurance carrier _____ Policy No._____

I give permission for full participation in BSA programs, subject to limitations noted herein.

In case of emergency, I understand every effort will be made to contact me (if participant is an adult, my spouse or next of kin). In the event I cannot be reached, I hereby give my permission to the licensed health-care practitioner selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child (or for me, if participant is an adult).

Date_____ Signature of parent/guardian or adult_____

Date updated_____ Signature of parent/guardian or adult _____

Date updated_____ Signature of parent/guardian or adult_____

Some hospitals require the parent/guardian signature to be notarized. Check with your BSA local council.

Check all items that apply, **past or present,** to your health history. Explain any "Yes" answers.

ALLERGIES: Food, medicines, insects, plants Yes ☐ No ☐ Explain:_____

GENERAL INFORMATION:	Yes	No		Yes	No		Yes	No
ADHD (Attention-Deficit Hyperactivity Disorder	☐	☐	Convulsions/seizures	☐	☐	Hemophilia	☐	☐
Asthma	☐	☐	Diabetes	☐	☐	High blood pressure	☐	☐
Cancer/leukemia	☐	☐	Heart trouble	☐	☐	Kidney disease	☐	☐

Explain: _____

Please list ALL medications taken in the 30 days **prior** to arrival at the Scouting activity where this form is to be used: _____

_____

List any medications to be taken at camp:_____

List any physical or behavioral conditions that may affect or limit full participation in swimming, backpacking, hiking long distances, or playing strenuous physical games: _____

List equipment needed such as wheelchair, braces, glasses, contact lenses, etc.:_____

Immunizations: (Give date of last inoculation.)

Tetanus toxoid _____	Measles _____	Polio _____
Diphtheria _____	Mumps _____	_____
Pertussis _____	Rubella _____	_____