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OA Lodge Operating

Wa-La-Moot-Kin Lodge 336
Blue Mountain Council BSA
8478 W. Gage Boulevard
Kennewick, WA 99336



Spring/Fall Ordeal Weekend Registration

Brotherhood Candidate

Please Print Clearly

Event Date (circle): May 21-23, 2010 or Aug 20-22, 2010

| | | | | | |
|----------------------------------|------------------------------------|----------------------|------------------------|----------------------------------|--|
| 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: (\$30/35 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

**_____ : address no later than
three weeks before event date. After that, event fee is \$35.**