CUB SCOUTS
OFF TO THE RACES
Day Camp & Cub Scout/Webelos Resident Camp

Housatonic Council Day Camp and Edmund D. Strang Scout Reservation are Nationally Accredited Cub Scout and Webelos Day and Resident Camps operated by Housatonic Council, BSA.

HOUSATONIC COUNCIL, BSA
111 New Haven Ave Derby, CT 06418
Dear Scouts, Families and Friends,

Please join us this summer for our Cub Scout summer camp programs. On behalf of myself and the entire summer camp staff, welcome!

Camping is the keystone to any scouting program. We are excited to return to Warsaw Park located in Ansonia, CT. Our day camp is a Nationally Accredited Camp by the Boy Scouts of America and meets all standards set forth by the National Office of the Boy Scouts of America for the operation of a Cub Scout Day or Resident Camp.

Housatonic Council Day Camp and Resident Camp is open to youth ranging from current Lions to Webelos (ages 5 - 11).

If you are interested in an overnight resident camp (sleep-away) try Camp Strang where your whole family can participate. Located in the foothills of Litchfield County. Camp Strang is 184 acres of forest, fields and streams provide the back drop to an exciting scouting experience.

Camping is a great scouting experience that every youth should experience. This is where their resourcefulness and self-reliance grows, where the outdoors become a lifelong source of recreation. A place youth will learn a lot and have fun! We hope your child will join us this summer for the adventure of a lifetime.

Yours in Scouting,

Ben Wheeler
Scout Executive

Housatonic Council
111 New Haven Ave., Derby, CT 06418
Phone: (203) 734-3329 ★ www.housatonicbsa.org
Camp Information

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DIRECTIONS TO CAMP

CUB SCOUT DAY CAMP
WARSAW PARK, ANSONIA, CT
125 Pulaski Hwy, ANSONIA, CT
(Directions from the Housatonic Council Service Center)
• Head South on CT-34 E/ New Haven Avenue
• Turn left on Sodom Lane
• Turn left onto Marshall Lane
• Turn right onto CT-243
• 125 Pulaski Hwy, Ansonia, CT

CUB/WEBELOS RESIDENT CAMP
EDMUND D. STRANG SCOUT RESERVATION, GOSHEN, CT
278 West Side Road, Goshen, CT
• From the Lower Naugatuck Valley, follow Route 8 North towards Torrington.
• Take Exit 44 onto Route 4 West towards Goshen.
• Follow Route 4 West approximately 6 miles to Goshen.
• At the rotary, take a right onto Route 63 North.
• West Side Road is the first left past St. Thomas Roman Catholic Church.
• Follow West Side Road for approximately one mile. The Main camp entrance will be on the right side of the road past the Caretaker’s house.
• At Camp Strang all vehicles must be parked in the main parking lot.
Cub Scout Day Camp

HOUSATONIC COUNCIL DAY CAMP will be held at

WARSAW PARK
125 Pulaski Hwy
Ansonia, CT  06401

SAFETY IS OUR TOP PRIORITY
Our camps are staffed daily by a certified health officer. Cub Scout Day Camp meets or exceeds National BSA Camp Standards and Complies with Connecticut State Law for youth camps.

FOOD
Lunch/snacks to be brought daily from home. Lunch to be provided to Campers attending Week 2’s Friday Field Trip to Camp Strang.

INSURANCE
Housatonic Council provides secondary health and accident insurance for participants, which covers costs not paid by the primary carrier. Non-Housatonic Council participants need to provide proof of council/unit insurance.

VISITORS
All visitors must sign in and out at camp headquarters.

Cub Scout Day Camp schedule for 2023

Week 1    July 31 to August 4
LOCATION: Warsaw Park
RANKS: Lions - Webelos
Monday: Check in 8-9 am

Week 2    August 7 to August 11
LOCATION: Warsaw Park
RANKS: Lions - Webelos
SPECIAL: Friday Field Trip to Camp Strang included in the fee—lunch provided!
Monday: Check in 8-9 am

Cub Scout Day Camp is an organized summer program. Campers participate in a rotating variety of activities.

DROP OFF (T-F) 8:30-9 am
PICK UP 4-4:30 pm
WHAT TO PACK

- Swim Suit
- Towel
- Swimming Shoes
- Sneakers
- Canteen or Water Bottle
- Sweatshirt or Jacket
- Extra shorts/pants/t-shirt/socks
- Bug Repellent (non-aerosol)
- Sun Screen

LUNCH
Lunch will be provided Friday of Week 2 on our field trip to Camp Strang.

AT CAMP STRANG, a healthy snack and lunch will be provided in the dining hall (included in your camp fee).

REQUIRED MEDICAL FORMS
All cub scouts and adult volunteers are required to submit their medical form prior to the start of camp. MAKE COPIES!!! Health forms will not be returned, per state law. No medical examinations can be given at camp.

CAMP TRADING POST
The camp trading post will be open each day offering a variety of snacks, treats, scout items, and small toys for purchase.

MEDICATIONS
All medications for scouts and adults needed while at camp must be turned into the health officer during check-in. Each form of medication must have a date as well as a doctor’s name on the container. Medications must be in the original container with an attached photo! Non-prescription medication must be left with the health officer also. This is a state law.

**Medications must be picked up prior to leaving camp at the end of the week. All medications left behind are destroyed two weeks after the end of camp.**
Cub Scout & Webelos Resident Camp

CUB RESIDENT PROGRAM @ Strang July 5th—July 8th
The program provides a fun and educational experience for youths. Each Pack is assigned to a campsites together with Pack leaders. The Pack stays together all day for the duration of your stay as they follow a structured program. This program will run alongside the Webelos Resident Camp program starting on Wednesday morning and concluding Saturday morning.

CUB SCOUT LEADERSHIP POLICY
PARENTS OF PARTICIPANTS ARE STRONGLY ENCOURAGED TO ATTEND! It is the policy of the Boy Scouts of America that at least 2 adult leaders, one of whom must be 21 years of age or older, are required for camping as a unit. Camp Strang works with Packs to combine Leadership when needed. Camp Strang maintains a 5 to 1 ratio during Cub/Webelos week.
Volunteer leaders are responsible for a group of youths during the week. Parents are asked to pass along any pertinent information to the Leader during check-in to help ensure that the Leader is prepared to give each camper the best experience possible.

WEBELOS RESIDENT PROGRAM
Similar to the Cub Resident Program, the Webelos Program is centered around fun and educational experiences for youth. Each Pack is assigned to a campsites together with Pack leaders. The Pack stays together for the duration of your stay as they follow a structured program. Afternoon activities may vary. Participants will see all program areas in camp.

WEBELOS LEADERSHIP POLICY
PARENTS OF PARTICIPANTS NEED NOT ATTEND. Each Pack is asked to send at least two leaders. Camp Strang staff will work with Packs to combine leadership when needed. All adults staying in camp must bring their Youth Protection training certificate! It is the policy of the Boy Scouts of America that at least 2 adult leaders, one of whom must be 21 years of age or older, are required for all camping. Camp Strang works with Packs to combine Leadership when needed. Camp Strang maintains a 5-to-1 ratio during Webelos week. Volunteer Pack leaders are responsible for a group of youths during the week. Parents are asked to pass along any pertinent information to the Pack Leader during check-in to help ensure that the Pack Leader is prepared to give each camper the best experience possible. Some pack leaders choose to split the week.
Cub Scout and Webelos Resident Camp is an organized program for ALL Cub Scouts. It is conducted at the Edmund D. Strang Scout Reservation. Activities include: Ga-ga ball, swimming, canoeing sports, archery, nature, & more. It’s safe and fun for everyone. Resident camp is the camp that youths come to for the adventure of a lifetime.

WHAT TO PACK

- Swimming Suit
- Towel
- Sneakers
- Water Bottle
- Clothing for # of Days
- Sweatshirt or Jacket
- Socks
- Pajamas
- Undergarments
- Sleeping Bag
- Pillow
- Foot Locker (recommended)

- Bug Repellent (non-aerosol)
- Sun Screen
- Soap
- Shampoo/Conditioner
- Toothpaste & Brush, Floss
- Flashlight
- Insect Netting & Poles
- Flashlight
- Pocketknife and Whittling Chip Card

TYPICAL DAY AT CAMP STRANG

6:30 - Polar Bear Swim
8:00 - Breakfast
9:00-12:00 - Morning Activities
12:30 - Lunch
1:00 - Siesta
2:00-4:00 - Afternoon Activities
4:00- 5:00  Free Swim
6:00 - Dinner
7:00-8:00 - Evening Activities
8:00 - Campfires in sites
9:30 - Lights out

DO NOT PACK

ELECTRONICS

FOOD
Gear up for a FUN and an EXCITING program where Scouts work towards requirements for the CUB SCOUT 2023-2024 program year...

Scouts will bring home an advancement sheet of what they accomplished.

**CHECK-IN PROCEDURE**
Parents are to check-in scouts at the check-in area Tierney Building (STEM CENTER) 9 am

Cub Scouts are to arrive with bathing suits on for swim tests. Once Packs are assembled, pack leaders may escort their packs to the waterfront beginning at 9:30 am

**CHECK-OUT PROCEDURE**
Parents are welcome to arrive Saturday morning for breakfast (need to have meal ticket) beginning at 8:00 am

There will be a closing ceremony immediately following breakfast. Scouts will be dismissed to their parents following the closing at approximately 9:00 am
# 2023 CUB SCOUT DAY CAMP REGISTRATION FORM

$25 deposit per Camper due by June 1, 2023. After June 1, 2023 add $25 per week

<table>
<thead>
<tr>
<th>Pack No.</th>
<th>Parent Last Name</th>
<th>Parent First Name</th>
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<th>Home Phone Number</th>
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<th>Email Address</th>
<th>Parent Signature</th>
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## AVAILABLE WEEKS OF CAMP

### WEEK 1
- **FEE: $260**
- **Monday, July 31st - Friday, Aug 4th**
- **WARSAW PARK**
- Field Trip to Camp Strang

### WEEK 2
- **FEE: $260**
- **Monday, Aug 7th - Friday, Aug 11th**
- **WARSAW PARK**

## Select Weeks for Campers in the Family

### 1st Camper
- **Name**
- **Date of Birth**
- **Shirt Size:** YM YL YXL
- **Rank as of Sept. 2023**
- **Week 1**
- **Week 2**

### 2nd Camper
- **Name**
- **Date of Birth**
- **Shirt Size:** YM YL YXL
- **Rank as of Sept. 2023**
- **Week 1**
- **Week 2**

### Fees:
- Scouts attending 2 weeks of camp will receive a $60 Discount ($200)
- Family’s sending a 2nd youth will also receive a $60 Discount

Make checks payable to: Housatonic Council, BSA

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Deposit of $25 per week per person due by June 1, 2023

Late Charge of $25 per week per person if signing up after June 1, 2023

## Payment by Cash or Check

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<th>Check #:</th>
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Remit to:

- Housatonic Council, BSA
- 111 New Haven Avenue
- Derby, CT 06418

## Credit Card Payment

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Signature:
Resident Camp at Strang
REGISTRATION FORM

Name: __________________________________ Age: ______ Birth date: _____ / _____ / _____
Address: __________________________________ Town: _______________ State: ______ Zip: ______
Phone: _______________________________ Unit #: ______ Unit's Town: _______________________
School Name: ___________________________________ Town: __________________________

**Rank as of September 2023:**  Lion  Tiger  Wolf  Bear  Webelos I  Webelos 2

Name of Adult Attending Camp with Scout: ________________________________
Parents Signature (Required): ____________________________________________

**CUB SCOUT and WEBELOS RESIDENT CAMP AT CAMP STRANG**
Rate includes a $25 non-refundable deposit.

<table>
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<tr>
<th>SESSION</th>
<th>CAMP SESSION</th>
<th>CAMP RATE</th>
<th>EARLY BIRD</th>
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<tbody>
<tr>
<td>#1</td>
<td>CUB &amp; WEBELOS RESIDENT CAMP: Adults and Cubs (One Parent attends Free with each Cub Scout) Wednesday, July 5th- Saturday, July 8th</td>
<td>$350</td>
<td>$325</td>
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Total $___________
Campership -$___________
Unit Paying -$___________
Total Amount Due $___________

**OFFICE USE ONLY:**
Camp Week: ______ Amount paid: _____________ Verified by: _____________ Amount of refund: ______
Authorized by: _____________
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Each medication to be administered by the health officer will need to have the Authorization for the Administration of Medication by School. Child Care, and Youth Camp Personnel form completed, filled out and signed by a doctor for each medication to be administered including any over the counter vitamins, inhalers and EpiPens.

If this form is not completed – the medication cannot be administrated.

**PLEASE NOTE***

- Camp Medical
- Medical Form Addendum
- Authorization for the Administration of Medications

Should be brought to camp and not the Council Office and turned in at check in.
In Connecticut schools, Child Care Centers and Group Care Homes, licensed Family Care Homes, and licensed Youth Camps administering medications to children shall comply with all requirements regarding the Administration of Medications described in the State Statutes and Regulations. Parents/guardians requesting medication administration to their child shall provide the program with appropriate written authorization(s) and the medication before any medications are administered. Medications must be in the original container and labeled with child’s name, name of medication, directions for medication’s administration, and date of the prescription.

**Authorized Prescriber’s Order (Physician, Dentist, Optometrist, Physician Assistant, Advanced Practice Registered Nurse or Podiatrist):**

Name of Child/Student: __________________________ Date of Birth ___/___/___ Today’s Date ___/___/___

Address of Child/Student: __________________________ Town __________________________

Medication Name/Generic Name of Drug, __________________________ Controlled Drug? ☐ YES ☐ NO

Condition for which drug is being administered: __________________________

Specific Instructions for Medication Administration __________________________

Dosage __________________________ Method/Route, __________________________

Time of Administration __________________________ If PRN, frequency __________________________

Medication shall be administered: Start Date: ___/___/___ End Date: ___/___/___

Relevant Side Effects of Medication __________________________ ☐ None Expected

Explain any allergies, reaction to/negative interaction with food or drugs, __________________________

Plan of Management for Side Effects __________________________

Prescriber’s Name / Title __________________________ Phone Number (_____) __________________________

Prescriber’s Address __________________________ Town __________________________

Prescriber’s Signature __________________________ Date ___/___/___

School Nurse Signature (if applicable) __________________________

Parent/Guardian Authorization:

☐ I request that medication be administered to my child/student as described and directed above

☐ I hereby request that the above ordered medication be administered by school, child care and youth camp personnel, and I give permission for the exchange of information between the prescriber and the school nurse, child care nurse or camp nurse necessary to ensure the safe administration of their medication. I understand that I must supply the school with no more than a three (3) month supply of medication (school only).

☐ I have administered at least one does of the medication with the exception of emergency medications to my child/student without adverse effects. (For child care only)

Parent/Guardian Signature __________________________ Relationship __________________________ Date ___/___/___

Parent/Guardian’s Address __________________________ Town __________________________ State ______

Home Phone # (_____) _____ · __________ Work Phone # (_____) _____ · __________ Cell Phone # (_____) _____ · __________

**SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL**

Self-administration of medication may be authorized by the prescriber and parent/guardian and must be approved by the school nurse (if applicable) in accordance with board policy. In a school, inhalers for asthma and cartridge injectors for medically-diagnosed allergies, students may self-administer medication with only the written authorization of an authorized prescriber and written authorization from a student’s parent or guardian or eligible student.

Prescriber’s authorization for self-administration: ☐ YES ☐ NO __________________________ Signature Date

Parent/Guardian authorization for self-administration: ☐ YES ☐ NO __________________________ Signature Date

School nurse, if applicable, approval for self-administration: ☐ YES ☐ NO __________________________ Signature Date

Today’s Date __________________________ Printed Name of Individual Receiving Written Authorization and Medication __________________________

Title/Position __________________________ Signature (in ink or electronic) __________________________

**Note:** Their form is in compliance with Section 10-212a, Section 19a-79-9a, 19a-87b-17 and 19-13-827a(v.)
MEDICAL ADDENDUM

REQUIRED FORM

to attend Camp Strang!

(must be completed by parent/guardian for scouts under 18 years old)

Scout____________________________ WEEK 2 FIELD TRIP/RESIDENT CAMP

This addendum to the Annual BSA Health and Medical Record is for scouts under 18 years of age and is required to meet Connecticut Department of Health requirements.

I give my permission for the camp Health Officer/Nurse to administer over-the-counter medications as directed by the Camp Physician in the Camp Standing Orders. The Housatonic Council’s policies on medications at scout camp are written to comply with the National Standards of the Youth Scouts of America and the State of Connecticut Health Department.

If you do not wish to have any of the following over-the-counter medications administered, please cross out and initial.

Over-the-Counter Medications may include:

(Generics may be substituted)

- Tylenol by mouth, per weight/age dosing as needed every 4-6 hours
- Advil by mouth, per weight/age dosing as needed every 6-8 hours
- Bacitracin/Neosporin/Hydrogen Peroxide topically as needed
- Hydrocortisone Cream topically every 6 hours as needed
- Benadryl by mouth, per weight/age dosing as needed, per package directions
- Claritin by mouth, per package directions
- Sudafed by mouth, per package directions
- Zantac by mouth, per package directions
- Sunscreen topically, as needed
- Bug repellent topically, as needed every 2-4 hours
- Solarcaine/Aloe Vera topically as needed every 2-4 hours

Signature____________________________ Date___________

**REMINDER - Prescription medications must be in the original pharmacy container with label, this includes EPI-Pens. Please bring only amount needed for camp. Failure to comply will result in the inability for the medications to be administered at camp. Any medication not picked up with-in 1 week after scout leaves camp will be destroyed.**
THIS PAGE LEFT INTENTIONALLY BLANK
**Part A: Informed Consent, Release Agreement, and Authorization**

Full name: ____________________________

Date of birth: ________________________

**Informed Consent, Release Agreement, and Authorization**

I understand that participation in Scouting activities involves the risk of personal injury, including death, due to the physical, mental, and emotional challenges in the activities offered. Information about these activities may be obtained from the venue, activity coordinators, or your local council. I also understand that participation in these activities is entirely voluntary and requires participants to follow instructions and abide by all applicable rules and the standards of conduct.

In case of an emergency involving me or my child, I understand that efforts will be made to contact the individual listed as the emergency contact person by the medical provider and/or adult leader. In the event that this person cannot be reached, permission is hereby given to the medical provider selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for me or my child. Medical providers are authorized to disclose protected health information to the adult in charge, camp medical staff, camp management, and/or any physician or health-care provider involved in providing medical care to the participant. Protected Health Information (PHI/PII) will be shared with the Standards for Privacy of Individually Identifiable Health Information, 45 CFR §§160.103, 164.501, etc. seq., as amended from time to time, includes examination findings, test results, and treatment provided for purposes of medical evaluation of the participant, follow-up, and communication with the participant’s parents or guardian, and determination of the participant’s ability to continue in the program activities.

I also hereby assign and grant to the local council and the Boy Scouts of America, as well as their authorized representatives, the right and permission to use and publish the photographs/film/videos/electronic representations and/or sound recordings made of me or my child at Scouting activities, and hereby release the Boy Scouts of America, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with the activity from any and all liability from such use and publication. Further, I authorize the reproduction, sale, copyright, exhibit, broadcast, electronic storage, and/or distribution of said photographs/film/videos/electronic representations and/or sound recordings without limitation at the discretion of the BSA, and I specifically waive any right to any compensation I may have for any of the foregoing.

Every person who furnishes any BB device to any minor, without the express or implied permission of the parent legal guardian of the minor, is guilty of a misdemeanor. (California Penal Code Section 199.95)[8] My signature below on this form indicates my permission.

☐ Checking this box indicates you DO NOT want your child to use a BB device.

NOTE: Due to the nature of programs and activities, the Boy Scouts of America and local councils cannot continually monitor compliance of program participants or any limitations imposed upon them by parents or medical providers. However, so that leaders can be as familiar as possible with any limitations, list any restrictions imposed on a child participant in connection with programs or activities below.

List participant restrictions, if any: □ None

I understand that, if any information I have provided is found to be inaccurate, it may limit and/or eliminate the opportunity for participation in any event or activity. If I am participating at Philmont Scout Ranch, Philmont Training Center, Northern Tier, Sea Base, or the Summit Bechtel Reserve, I have also read and understand the supplemental risk advisories, including height and weight requirements and restrictions, and understand that the participant will not be allowed to participate in applicable high-adventure programs if those requirements are not met. The participant has permission to engage in all high-adventure activities described, except as specifically noted by me or the health-care provider. If the participant is under the age of 18, a parent or guardian’s signature is required.

Participant’s signature: __________________________ Date: ____________

Parent/guardian signature for youth: __________________________ Date: ____________

(If participant is under the age of 18)

**Complete this section for youth participants only:**

**Adults Authorized to Take Youth to and From Events:**

You must designate at least one adult. Please include a phone number.

Name: __________________________ Name: __________________________

Phone: __________________________ Phone: __________________________

**Adults NOT Authorized to Take Youth to and From Events:**

Name: __________________________ Name: __________________________

Phone: __________________________ Phone: __________________________

**Prepared. For Life.**

600-001
2019 Printing
## Part B1: General Information/Health History

**Full name:**

**Date of birth:**

- **Age:**
- **Gender:**
- **Height (inches):**
- **Weight (lbs.):**

**Address:**

**City:**
**State:**
**ZIP code:**
**Phone:**

**Unit leader:**
**Unit leader’s mobile #:**

**Council Name/No.:**
**Unit No.:**

**Health/ Accident Insurance Company:**
**Policy No.:**

⚠️ Please attach a photocopy of both sides of the insurance card. If you do not have medical insurance, enter “none” above.

**In case of emergency, notify the person below:**

- **Name:**
- **Relationship:**
- **Address:**
- **Home phone:**
- **Other phone:**
- **Alternate contact name:**
- **Alternate’s phone:**

### Health History

**Do you currently have or have you ever been treated for any of the following?**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Condition</th>
<th>Last HbA1c percentage and date:</th>
<th>Explain</th>
<th>Insulin pump: Yes</th>
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<tr>
<td></td>
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<td>Diabetes</td>
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<td>Hypertension (high blood pressure)</td>
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<td>Congenital heart disease/heart attack/cheek pain (angina/ heart murmur/coronary artery disease. Any heart surgery or procedure. Explain all “yes” answers.</td>
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<td>Family history of heart disease or any sudden heart-related death of a family member before age 50.</td>
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<td>Head injury/concussion/TBI</td>
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<td></td>
<td></td>
<td>Altitude sickness</td>
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<td></td>
<td></td>
<td>Psychiatric/ Psychological or emotional difficulties</td>
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<td></td>
<td></td>
<td>Neurological/Behavioral disorders</td>
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<td></td>
<td></td>
<td>Blood disorders/Other cell disease</td>
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<td></td>
<td></td>
<td>Fainting spells and dizziness</td>
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<td></td>
<td></td>
<td>Kidney disease</td>
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<td></td>
<td></td>
<td>Seizures or epilepsy</td>
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<tr>
<td></td>
<td></td>
<td>Abdominal/stomach/digestive problems</td>
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<td></td>
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<tr>
<td></td>
<td></td>
<td>Thyroid disease</td>
<td></td>
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<td></td>
<td></td>
<td>Skin issues</td>
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<td></td>
<td></td>
<td>Obstructive sleep apnea/sleep disorders</td>
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<td></td>
<td></td>
<td>List all surgeries and hospitalizations</td>
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<td></td>
<td>List any other medical conditions not covered above</td>
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</tr>
</tbody>
</table>

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**Prepared. For Life.**

620-001
2010 Printing
**Part B2: General Information/Health History**

**Full name:** ____________________________________________________________

**Date of birth:** ________________________________________________________

**High-adventure base participants:**

Expedition/crew No.: __________________

or staff position: __________________

**Allergies/Medications**

**DO YOU USE AN EPINEPHRINE AUTOINJECTOR? Exp. date (if yes) □ YES □ NO**

**DO YOU USE AN ASTHMA RESCUE INHALER? Exp. date (if yes) □ YES □ NO**

Are you allergic to or do you have any adverse reaction to any of the following?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Allergies or Reactions</th>
<th>Explain</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Medication</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Food</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Allergies or Reactions</th>
<th>Explain</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Plants</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Insect bites/envenom.</td>
<td></td>
</tr>
</tbody>
</table>

List all medications currently used, including any over-the-counter medications.

☐ Check here if no medications are routinely taken. ☐ If additional space is needed, please list on a separate sheet and attach.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Frequency</th>
<th>Reason</th>
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</thead>
<tbody>
<tr>
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</tbody>
</table>

□ YES □ NO Non-prescription medication administration is authorized with these exceptions: ____________________________________________________________

Administration of the above medications is approved for youth by: ____________________________

Parent/guardian signature: ____________________________

MD/DO, NP, or PA must sign if your state requires a signature.

**Immunization**

The following immunizations are recommended. Tetanus immunization is required and must have been received within the last 10 years. If you had the disease, check the disease column and list the date. If immunized, check yes and provide the year received.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Had Disease</th>
<th>Immunization</th>
<th>Date(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Tetanus</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Pertussis</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td>Diphtheria</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td>Measles/mumps/rubella</td>
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<td></td>
<td></td>
<td>Polio</td>
<td></td>
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<td></td>
<td></td>
<td>Chicken Pox</td>
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<td></td>
<td></td>
<td>Hepatitis A</td>
<td></td>
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<td></td>
<td>Hepatitis B</td>
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<tr>
<td></td>
<td></td>
<td>Meningitis</td>
<td></td>
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<td></td>
<td></td>
<td>Influenza</td>
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<td></td>
<td></td>
<td>Other (i.e., Hib)</td>
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<tr>
<td></td>
<td></td>
<td>Exemption to immunizations (form required)</td>
<td></td>
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</tr>
</tbody>
</table>

**Bring enough medications in sufficient quantities and in their original containers. Make sure they are NOT expired, including inhalers and EpiPens. You SHOULD NOT STOP taking any maintenance medication unless instructed to do so by your doctor.**

**Immunization**

The following immunizations are recommended. Tetanus immunization is required and must have been received within the last 10 years. If you had the disease, check the disease column and list the date. If immunized, check yes and provide the year received.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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<th>Immunization</th>
<th>Date(s)</th>
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<tbody>
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<td></td>
<td>Tetanus</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Pertussis</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Diphtheria</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Measles/mumps/rubella</td>
<td></td>
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<td></td>
<td>Polio</td>
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<td>Chicken Pox</td>
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<td>Hepatitis A</td>
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<td>Meningitis</td>
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<td>Influenza</td>
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<td></td>
<td>Other (i.e., Hib)</td>
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<tr>
<td></td>
<td></td>
<td>Exemption to immunizations (form required)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Please list any additional information about your medical history:**

__________________________________________________________

__________________________________________________________

**DO NOT WRITE IN THIS BOX.**

Review for camp or special activity.

Reviewed by: ____________________________

Date: ____________________________

Further approval required: □ Yes □ No

Reason: ____________________________

Approved by: ____________________________

Date: ____________________________
Part C: Pre-Participation Physical

This part must be completed by certified and licensed physicians (MD, DO), nurse practitioners, or physician assistants.

Full name: ____________________________

Date of birth: _______________________

High-adventure base participants:
Expedition/crew No.: __________________
or staff position: ____________________

You are being asked to certify that this individual has no contraindications for participation in a Scouting experience. For individuals who will be attending a high-adventure program, including one of the national high-adventure bases, please refer to the supplemental information on the following pages or the form provided by your patrol. You can also visit www.scouting.org/health-and-safety/ahmr to view this information online.

Please fill in the following information:

<table>
<thead>
<tr>
<th>Medical restrictions to participate</th>
<th>Yes</th>
<th>No</th>
<th>Explain</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Allergies or Reactions</th>
<th>Explain</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Medication</td>
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<td>Food</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Allergies or Reactions</th>
<th>Explain</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Plants</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Insect bites/stings</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Height (inches)</th>
<th>Weight (lbs.)</th>
<th>BMI</th>
<th>Blood Pressure</th>
<th>Pulse</th>
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</thead>
<tbody>
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</table>

Examiner's Certification

I certify that I have reviewed the health history and examined this person and find no contraindications for participation in a Scouting experience. This participant (with noted restrictions):

- [ ] Normal
- [x] Abnormal

Examine Abnormalities

Eyes: [ ]

Ears/none/throat: [ ]

Lungs: [ ]

Heart: [ ]

Abdomen: [ ]

Genitalia/urinary: [ ]

Musculoskeletal: [ ]

Neurological: [ ]

Skin issues: [ ]

Other: [ ]

Examiner's signature: __________________ Date: _______________

Examiner's printed name: __________________

Address: ____________________________

City: __________________ State: ___________ ZIP code ___________

Office phone: ________________________

Height/Weight Restrictions

If you exceed the maximum weight for height as explained in the following chart and your planned high-adventure activity will take you more than 30 minutes away from an emergency vehicle accessible roadway, you may not be allowed to participate.

Maximum weight for height:

<table>
<thead>
<tr>
<th>Height (inches)</th>
<th>Max. Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>60</td>
<td>166</td>
</tr>
<tr>
<td>61</td>
<td>172</td>
</tr>
<tr>
<td>62</td>
<td>176</td>
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<td>63</td>
<td>180</td>
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<td>184</td>
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<td>201</td>
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<td>214</td>
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<td>246</td>
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<td>74</td>
<td>252</td>
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<td>76</td>
<td>264</td>
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<td>77</td>
<td>270</td>
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<td>78</td>
<td>276</td>
</tr>
<tr>
<td>79 and over</td>
<td>282</td>
</tr>
</tbody>
</table>

Prepared. For Life.
CAMP SCHOLARSHIP FUND APPLICATION

To apply a $25 non refundable deposit is needed to process this campership application along with Unit Leader’s Signature.

Name: _________________________________ Age (as of 7/1/2023) ______________________________

Address: _______________________________ City _______________________ State ______ Zip ______

Telephone: _____________________________ Unit: Pack Troop Crew (circle one) #___________________

Parent – Briefly explain your need for campership assistance:

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

This youth is planning on attending _____________ week(s) of camp.

Applying for:

☐ Cub Scout/Webelos Resident Camp   ☐ Cub Scout Day Camp week of _____________

I can afford to pay the following $ ___________________ towards my child’s week (s) at camp.

The unit will be contributing $____________________ towards my child’s week(s) of camp.

Number of persons in household __________ Gross Income $________________

I understand that this is an application, and in no way guarantees a camp scholarship. I further understand that Housatonic Council awards partial camp scholarship and that scouts are encouraged to earn part of their camp fee. This is limited to Housatonic Council Camp facilities.

Parents Name (please print) __________________________________________________________________

Address:  _______________________________________City ___________________ State ____ Zip ______

Parent’s Signature: __________________________________________________________________________

Mail to: Camperships Committee, Housatonic Council BSA, 111 New Haven Avenue, Derby, CT 06418

This applicant is a registered scout within my unit.

Unit Leader’s Signature: ___________________________________________ Date: _______________

Service Center Use Only
Date Received in Office ______________________
REQUEST FOR REFUND
Housatonic Council, BSA

Refund Policy for Housatonic Council

All requests must be received by August 31\textsuperscript{ST} and must have the Unit Leader’s approval (signature) to be considered for refund. If a Scout will be missing days during a Camp period, that Scout needs to notify the Camp Director at check in time. No refund will include the non-refundable $25.00 deposit.

\textit{The only circumstances under which refunds will be granted are as follows:}
1. Illness of Scout prevents their attendance at summer camp
2. Illness or death in the campers’ immediate family prevents their attendance at camp
3. Family relocation making attending camp impractical
4. Mandatory attendance at summer school that is verifiable
5. A Scout leaves camp for medical reasons (home sickness is not considered a refundable medical reason) must be certified by the Camp Health Officer or Camp Director. In such cases, the Scout will receive a pro-rated refund for the unused portion of the camp fee. If the unused portion constitutes three or more days and the medical excuse is not due to horseplay or negligence of said Scout.

Absolutely no refunds will be granted for “No Shows” or Days Missed.

Scouts name: _________________________________ Troop/Pack _______________________
Address: ____________________________________ City: ___________________State: ______
Zip: __________________
Parents Name: _____________________________________________
Phone #: ___________________________ Cell Phone: _________________________________
Camp Attending and Date(s): ______________________________________________________
Reason for Refund_______________________________________________________________

\textbf{Mail to:} Housatonic Council, BSA, 111 New Haven Avenue, Derby, CT 06418
JOIN US THIS SUMMER AT CAMP!

HOUSATONIC COUNCIL, BSA
111 NEW HAVEN AVENUE
DERBY, CT 06418
(203)734-3329