

# Weird Science

## We count on our volunteers to make camp a success!

Please sign up only for days you plan to volunteer at day camp. Placeholders and those signing up only to meet ratio make it difficult for camp staff to assign adult volunteer positions and ensure that each station and den are adequately staffed.

If you are unable to work on the days you signed up, please notify Camp Staff immediately!

- Each Pack is required to support day camp by registering one adult volunteer per every 3 Scouts registered per day.
- All Volunteers must check in by 8:00am each day and must be wearing proper uniform during camp.
- Smoking or chewing tobacco is not allowed within view of any Scouts.
- By completing the adult volunteer application, you acknowledge you are not currently on parole or probation for a felony.
- For safety reasons, **REGISTERED CUB SCOUTS AND YOUTH VOLUNTEERS ONLY ALLOWED AT CAMP.** No child care is provided.
- Siblings 14 years and older may participate ONLY if they register as a volunteer.
- **No Pets of any kind, service animals allowed with certificate**
- **Unless there is a medical necessity, scouts will not be assigned with their natural den leaders or their parents!!!! Please contact Camp Staff with any specific requests.**
- **What to Wear:** shorts, hat, socks and tennis shoes (**NO open-toed shoes**), sunscreen; camp t-shirt.
- **What to Bring:** snack, sack lunch, large bottle of water and a smiling face!
- **Do Not Bring:** chewing gum, firearms, expensive jewelry, illicit drugs, alcohol, electronics.

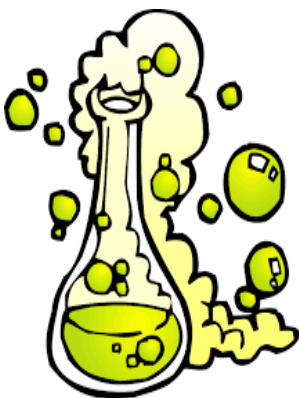
### Volunteer Position Descriptions:

**Camp Den Leader:** Arrive early each day to set up your den area; have parents sign-in/out scouts; Lead your "den" through each assigned station; be positive role model and use calm discipline at all times; Assist scouts at stations as needed; be prepared to participate in all activities; monitor scouts' food and water intake; address discipline issues with care; ensure den is enthusiastic and team oriented; encourage Scout participation in ALL activities; ensure "buddy system" is strictly enforced; ensure all Scouts are welcome in their Den. Unless there is a medical necessity, scouts will not be assigned with their natural den leaders or their parents.

**Craft or Handicraft Station Leader:** Set up in the morning and pack up supplies at end of day; track supplies to ensure adequate quantity for week; contact Camp Staff if you are having problems with your station; learn assigned project/program for your station and exact steps; be able to provide instructions clearly & enthusiastically to Scouts as they come to your station.

**Rec/Water Games Leader:** Lead scouts in physical activities; be flexible with games – if it isn't working, try something new; enforce good sportsmanship

**Range:** Must attend council range training, assist in set up and tear down of range; monitor scouts to ensure proper range safety; must follow principles in *Boy Scouts of America Shooting Sports Guide*.



Please understand that we will try to accommodate specific position requests. However, assignments will be made as needed and in the best interest of running a safe and fun day camp!

**PLEASE COMPLETE AND RETURN YOUR VOLUNTEER FORMS AS SOON AS POSSIBLE**



# Northern Rivers District 2021 Cub Scout Day Camp Volunteer Registration - \$13

Pack #: \_\_\_\_\_

**DIRECTIONS:** Fill out the ENTIRE form. Return completed registration form, medical form and **copy of insurance card** to your day camp coordinator. Volunteers should be a BSA registered adult and **MUST** complete Youth Protection Training prior to Day Camp. **REGISTRATION MUST BE ACCOMPANIED BY MEDICAL FORM!**

**A volunteer orientation will be held the Thursday evening prior to Day camp. Please plan to attend one of this volunteer orientation session.**

**T-Shirt Size:**  Adult Medium  Adult Large  Adult X-Large  Adult 2X-Large  Adult 3X-Large  Adult 4X-Large

**PLEASE PRINT NEATLY**

Name \_\_\_\_\_  
Mailing Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Phone # \_\_\_\_\_ Email \_\_\_\_\_

PLEASE CHECK ALL THAT APPLY:  I hold a CPR card.  I hold a first aid card.  I am an EMT, RN, FNP, PA-C or MD/DO.

**Emergency Contact Information:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

**PLEASE CHECK ALL DAYS THAT YOU ARE COMMITTING TO VOLUNTEER AT DAY CAMP.**

- Tuesday  Wednesday  Thursday  Friday

By my signature, I agree to be present at Cub Scout Day Camp on the days checked above. I will inform Camp Staff immediately if my availability changes and understand that I am responsible for finding a replacement.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Your Cub Scout Day Camp assignment will be based on day camp needs.

- I have a specific request for position (range officer, 1:1 adult with scout, den leader, etc). \_\_\_\_\_  
 Please contact me directly to discuss my needs. Best contact phone number \_\_\_\_\_

**What to wear:** Shorts, hat, socks and CLOSED TOE SHOES, sunscreen, camp t-shirt. Camp policy states that **NO OPEN TOED SHOES** are allowed in camp. This rule is enforced for all campers, staff, and visitors. Anyone arriving without proper footwear will remain at the registration area.

**What to bring:** Snack, sack lunch, bottle of water, and a SMILING FACE! (No electronics, weapons, gum, etc please.)

IN THE EVENT OF AN EMERGENCY, I understand that every effort will be made to contact the parents or emergency contact listed above. In the event no one can be reached, I hereby authorize the camp personnel to make such arrangements as deemed necessary in regards to transportation and emergency medical treatment.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ (parent/guardian must sign if under 18 years)



## Northern Rivers District 2021 Cub Scout Day Camp Volunteer Agreement

I agree to serve in the position of den leader or station leader. My first interest is the Cub Scout. The camp exists and operates for them. I understand that although I may request a specific position, camp staff may be unable to fulfill that request based on staffing needs.

I agree to serve as a volunteer in a manner consistent with the Cub Scout Promise, the Law of the Pack, and the National standards for Cub Scout Day Camp.

I also agree to the following:

- a. I have **committed** to work the days I indicated on the registration page.
- b. I will notify camp staff **immediately** if my availability to volunteer at camp changes prior to Day Camp. I understand that it is my responsibility to make sure the pack ratio of 1 adult per 3 scouts is maintained.
- c. I have taken Youth Protection training online within the last year at:  
<https://my.scouting.org>
- d. As day camp staff, I will wear the day camp t-shirt and CLOSED TOE SHOES every day. I will not alter the camp t-shirt.
- e. I will be at day camp each day by 8:00 am. On Tuesday, I will be at camp by 7:30 am in order to prepare my den or station.
- f. I will check in at registration and understand that my position MAY change from day to day.
- g. My car will be parked in the designated parking area.
- h. There will be no smoking, drinking, or drug use at day camp.
- i. Unless there is a medical necessity, scouts will not be assigned with their natural den leaders or parents. Please contact camp staff with any questions or concerns.

By signing below, I have read the adult volunteer agreement and understand the information provided and I agree to contact Camp Staff with any schedule changes or problems.

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Volunteer Signature

Date

## Part A: Informed Consent, Release Agreement, and Authorization

Full name: \_\_\_\_\_  
 Date of birth: \_\_\_\_\_

High-adventure base participants:  
 Expedition/crew No.: \_\_\_\_\_  
 or staff position: \_\_\_\_\_

### 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 those 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/Confidential Health Information (PHI/CHI) under the Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. §§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/or determination of the participant's ability to continue in the program activities.

(If applicable) I have carefully considered the risk involved and hereby give my informed consent for my child to participate in all activities offered in the program. I further authorize the sharing of the information on this form with any BSA volunteers or professionals who need to know of medical conditions that may require special consideration in conducting Scouting activities.


With appreciation of the dangers and risks associated with programs and activities, on my own behalf and/or on behalf of my child, I hereby fully and completely release and waive any and all claims for personal injury, death, or loss that may arise against the Boy Scouts of America, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with any program or activity.

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/ videotapes/electronic representations and/or sound recordings made of me or my child at all Scouting activities, and I 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. I further authorize the reproduction, sale, copyright, exhibit, broadcast, electronic storage, and/or distribution of said photographs/film/videotapes/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 or legal guardian of the minor, is guilty of a misdemeanor. (California Penal Code Section 19915(a)) My signature below on this form indicates my permission.*

I give permission for my child to use a BB device. (Note: Not all events will include BB devices.)

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/we 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: _____



## Part B1: General Information/Health History

Full name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

High-adventure base participants:

Expedition/crew No.: \_\_\_\_\_

or staff position: \_\_\_\_\_

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?

Yes	No	Condition	Explain
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	Last HbA1c percentage and date: _____ Insulin pump: Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Hypertension (high blood pressure)	
<input type="checkbox"/>	<input type="checkbox"/>	Adult or congenital heart disease/heart attack/chest pain (anginal)/heart murmur/coronary artery disease. Any heart surgery or procedure. Explain all "yes" answers.	
<input type="checkbox"/>	<input type="checkbox"/>	Family history of heart disease or any sudden heart-related death of a family member before age 50.	
<input type="checkbox"/>	<input type="checkbox"/>	Stroke/TIA	
<input type="checkbox"/>	<input type="checkbox"/>	Asthma/reactive airway disease	Last attack date: _____
<input type="checkbox"/>	<input type="checkbox"/>	Lung/respiratory disease	
<input type="checkbox"/>	<input type="checkbox"/>	COPD	
<input type="checkbox"/>	<input type="checkbox"/>	Ear/eyes/nose/sinus problems	
<input type="checkbox"/>	<input type="checkbox"/>	Muscular/skeletal condition/muscle or bone issues	
<input type="checkbox"/>	<input type="checkbox"/>	Head injury/concussion/TBI	
<input type="checkbox"/>	<input type="checkbox"/>	Altitude sickness	
<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric/psychological or emotional difficulties	
<input type="checkbox"/>	<input type="checkbox"/>	Neurological/behavioral disorders	
<input type="checkbox"/>	<input type="checkbox"/>	Blood disorders/sickle cell disease	
<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells and dizziness	
<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	
<input type="checkbox"/>	<input type="checkbox"/>	Seizures or epilepsy	Last seizure date: _____
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal/stomach/digestive problems	
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	
<input type="checkbox"/>	<input type="checkbox"/>	Skin issues	
<input type="checkbox"/>	<input type="checkbox"/>	Obstructive sleep apnea/sleep disorders	CPAP: Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	List all surgeries and hospitalizations	Last surgery date: _____
<input type="checkbox"/>	<input type="checkbox"/>	List any other medical conditions not covered above	





## 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  YES  NO

AUTOINJECTOR? Exp. date (if yes) \_\_\_\_\_

DO YOU USE AN ASTHMA RESCUE  YES  NO

INHALER? Exp. date (if yes) \_\_\_\_\_

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

Yes	No	Allergies or Reactions	Explain	Yes	No	Allergies or Reactions	Explain
<input type="checkbox"/>	<input type="checkbox"/>	Medication		<input type="checkbox"/>	<input type="checkbox"/>	Plants	
<input type="checkbox"/>	<input type="checkbox"/>	Food		<input type="checkbox"/>	<input type="checkbox"/>	Insect bites/stings	

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.

Medication	Dose	Frequency	Reason

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 signature (if your state requires signature)



Bring enough medications in sufficient quantities and in the original containers. Make sure that 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.

Yes	No	Had Disease	Immunization	Date(s)
<input type="checkbox"/>	<input type="checkbox"/>		Tetanus	
<input type="checkbox"/>	<input type="checkbox"/>		Pertussis	
<input type="checkbox"/>	<input type="checkbox"/>		Diphtheria	
<input type="checkbox"/>	<input type="checkbox"/>		Measles/mumps/rubella	
<input type="checkbox"/>	<input type="checkbox"/>		Polio	
<input type="checkbox"/>	<input type="checkbox"/>		Chicken Pox	
<input type="checkbox"/>	<input type="checkbox"/>		Hepatitis A	
<input type="checkbox"/>	<input type="checkbox"/>		Hepatitis B	
<input type="checkbox"/>	<input type="checkbox"/>		Meningitis	
<input type="checkbox"/>	<input type="checkbox"/>		Influenza	
<input type="checkbox"/>	<input type="checkbox"/>		Other (i.e., Hib)	
<input type="checkbox"/>	<input type="checkbox"/>		Exemption to immunizations (form required)	

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: \_\_\_\_\_

