

# 2012 SR-7B Cardinal Conclave – April 20-22, 2012

## Wahissa Delegate Registration Form

### Delegate Information:

BSA Member No. \_\_\_\_\_ Unit #: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State & Zip: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Email: \_\_\_\_\_ T-Shirt Size: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Chapter: \_\_\_\_\_

Ordeal/Brotherhood/Vigil: \_\_\_\_\_

Dietary needs: \_\_\_\_\_

Need Power Available for a CPAP Machine:  Yes  No

### Emergency Contact:

Name: \_\_\_\_\_

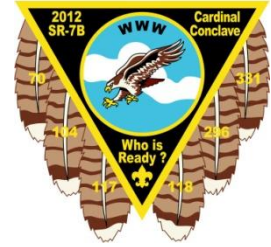
Relationship: \_\_\_\_\_

Day Telephone: \_\_\_\_\_

Evening Telephone: \_\_\_\_\_

I would like to be contacted about donating blood at the SR-7B Blood Drive   
(only check the box if you are 17 years or older)

This will be my first time attending conclave: (check the box)



**Due Date: March 1, 2012**

### Return to:

Wahissa Lodge  
Old Hickory Council  
6600 Silas Creek Parkway  
Winston-Salem, NC 27106

**Cost: \$40.00**

### Payment:

**Include Payment to:**  
Old Hickory Council

**Complete the Medical  
Form on the Reverse Side**

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

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## Delegate Medical Form

Lodge # \_\_\_\_\_

<b>To be filled out by parent/guardian or adult participant. Please print in ink.</b>		
<b>Delegate Information</b>		
Name:	Email:	
Address:		
City	State:	Zip Code:
Phone: (    )	Date of Birth:	
Circle One:	Ordeal	Brotherhood
	Vigil	
<b>Primary Emergency Contact</b>		
Name:	Relationship:	
Day Phone: (    )	Evening Phone: (    )	
<b>Secondary Emergency Contact</b>		
Name:	Relationship:	
Day Phone: (    )	Evening Phone: (    )	
<b>Medical Information</b>		
Do you: <input type="checkbox"/> have any medical restrictions? <input type="checkbox"/> currently take any medications? <input type="checkbox"/> have any dietary restrictions?	Explain:	
Health Insurance Company:	Policy #:	
Have or subject to: <input type="checkbox"/> Convulsions <input type="checkbox"/> Asthma <input type="checkbox"/> Fainting Spells <input type="checkbox"/> Bleeding disorder <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Trouble <input type="checkbox"/> Allergy to medication, food, plant, animal/insect <input type="checkbox"/> A condition requires special care, medication or diet <input type="checkbox"/> NONE OF THE ABOVE APPLY <input type="checkbox"/> Other	Explain:	
<input type="checkbox"/> Any condition now requiring regular medication?	Name of medication:	
<b>Last Tetanus toxiod date:</b>		
<p>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.</p> <p><b>In case of emergency</b>, 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)</p>		
Participant	Parent or Guardian	
Signature:	Signature (if participant under 18 years):	
Date: _____	Date: _____	

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