

**CUB SCOUT PACK 449 REGISTRATION & CONSENT FORM**  
**2011 SPRING FAMILY CAMPOUT AT FRANK G. LUMPKIN CAMPGROUND**  
**West Point Lake, Troup County, GA**  
**MAY 13 – 15, 2011**

**Registration:** You can submit this registration & consent form one of three ways:

1. Bring this completed registration and consent form to the Pack Meeting on 4/18/11
2. Scan and email a copy to alecsdad01@yahoo.com
3. Mail to Chris Reynolds, 6105 Poplar Spring Drive, Norcross GA 30092

Please be sure to inform your Den Leader if you are planning on attending so he/she can co-ordinate food and campsite duties.

**Registration Fee:** Waived (paid by pack). Remember that a scout must be accompanied by at least one adult family member.

**Registration Deadline:      FRIDAY, MAY 6, 2011**

Scout's Name: \_\_\_\_\_ Den #: \_\_\_\_\_ Rank: \_\_\_\_\_

Parent(s) Attending: \_\_\_\_\_

Name & Age of Sibling(s) Attending: \_\_\_\_\_

Total for Family Camping: Friday Night: \_\_\_\_\_ & Saturday Night: \_\_\_\_\_

Emergency Contact (Not Attending Campout) & Telephone:

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

Are you certified in First Aid or CPR? (Please specify which and indicate certifying agency and date certification expires) \_\_\_\_\_

Are you a medical professional? (Please specify physician, nurse, nurse practitioner, EMT, etc...): \_\_\_\_\_

**HOLD HARMLESS AGREEMENT**

I understand that participation in the activity involves a certain degree of risk. I have carefully considered the risk involved and have given consent for myself or my child to participate in the activity. I understand that participation in the activity is entirely voluntary and requires participants to abide by applicable rules and standards of conduct. I 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 claims or liability arising out of this participation.

In case of emergency involving my child, I understand every effort will be made to contact me. In the event I cannot be reached, I hereby give my permission to the medical provider selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child. Medical providers are authorized to disclose to the adult in charge 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.

Participant's signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/guardian printed name \_\_\_\_\_

Parent/guardian signature \_\_\_\_\_ Date \_\_\_\_\_