

DUES PAYMENT FORM PAWNEE CHAPTER - SIWINIS LODGE #252

Name: _____
PLEASE TYPE OR PRINT LEGIBLY AND COMPLETE ALL BLOCKS

Address: _____ City: _____ State: _____ Zip+4: _____ - _____

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____

Date of Birth: ____ \ ____ \ ____ o Youth (under 21) o Adult - Occupation (adults only): _____ **2007**

e-mail address : _____ // Parent email if youth _____

\$10 Youth on or before October 31st, \$25 after October 31st

\$15 Adult October 31st, \$25 after October 31st

Troop# _____ o Ordeal ____ \ ____ \ ____ o Brotherhood ____ \ ____ \ ____ o Vigil ____ \ ____ \ ____

Mail To: Ross Arnold
1910 N. Van Ness
Los Angeles, CA 90068

Make checks payable to:
Pawnee Chapter, Boy Scouts of America, OA

Siwinis Lodge # 252 – Medical Release Form

Name: _____

Medical Insurance: _____
Insurance Company Name Policy or Certificate # Policyholder's Name

Have or had difficulty with (check if yes):

- Asthma / Lungs
 - Convulsions
 - Heart trouble
 - Digestion
 - Eyes, ears, nose, throat
 - Any other conditions that may require special care, medication, or diet
- If yes, explain _____
- _____
- _____

- Fainting spells
- Diabetes
- Bleeding disorders
- Sleep walking

None of the above applies

Any condition now requiring medication? o Yes o No

If yes, name of medications(s) _____

Allergy to any medication, food, plant, animal or insect toxin?

Yes No

If yes, explain: _____

Any restrictions of activity for medical reasons? o Yes o No

If yes, explain: _____

Immunizations-Date of Last Inoculations

(Dates Required for Youth Members)

_____ Tetanus _____	_____ Polio _____
_____ Diphtheria _____	_____ Mumps _____
_____ Measles _____	_____ Rubella _____
_____ Pertussis _____	

Authorization for Medical Treatment

This health history is correct so far as I know and the person herein described has permission to engage in all prescribed activities except as noted by me. In the event of an emergency and I can not be reached, I hereby give my permission to the physician selected by the adult leader in charge to treat, hospitalize, secure proper anesthesia or to order injection for the person herein described.

Member Signature _____ Date _____

Signature of Parent or Guardian _____ Date _____
(Required if Member is under 18 years of age)

Home Phone: (____) _____ - _____

Work Phone: (____) _____ - _____

Cell Phone: (____) _____ - _____