

## NEW MEMBER FORM FOR SIWINIS LODGE #252

You must be a registered member of the Los Angeles Area Council - Boy Scouts of America to be a member of the Siwinis Lodge - Order of the Arrow. All adults 18 or older must have completed Youth Protection within the last two years.

Check one:  North Star – Apache  Thunderbird – Hopi  Pacifica – Lakota  
 Frontier – Wapp  Rio Hondo – Wiyot

Name: \_\_\_\_\_ BSA ID # \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_  YOUTH (under 21)  ADULT OCCUPATION \_\_\_\_\_

EMAIL: \_\_\_\_\_ PARENTS EMAIL: \_\_\_\_\_

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### Parental Informed Consent and Hold Harmless/Release Agreement

I understand that participation in Scouting activities 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 these activities. I understand that participation in these activities 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.

I approve the sharing of the information on this form with BSA volunteers and professionals who need to know of medical situations that might require special consideration for the safe conducting of Scouting activities.

In case of an emergency involving me or my child, I understand that every effort will be made to contact the individual listed as the emergency contact person. 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 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.

- Without restrictions.  
 With special considerations or restrictions (list)

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### Talent Release Form

I hereby assign and grant to the local council and the Boy Scouts of America the right and permission to use and publish the photographs / film / videotapes / electronic representations and / or sound recordings made of me or my child by the Boy Scouts of America, and I hereby release the Boy Scouts of America from any and all liability from such use and publication. I hereby 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 Boy Scouts of America, and I specifically waive any right to any compensation I may have for any of the foregoing.

Yes  No

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*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.*

Participant's name \_\_\_\_\_

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

Parent/guardian's signature \_\_\_\_\_

Date \_\_\_\_\_

*(if under the age of 18)*

# Annual Health and Medical Record

## General Information:

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  Male  Female  
 Health/accident insurance \_\_\_\_\_ Policy No. \_\_\_\_\_

## In case of emergency, notify:

Name: \_\_\_\_\_ Relationship \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Alternate contact: \_\_\_\_\_ 1st Phone: \_\_\_\_\_ 2nd Phone: \_\_\_\_\_

## Medical History:

Are you now, or have you ever been treated for any of the following:

Yes	No	Condition	Explain
		Asthma	
		Diabetes	
		Hypertension (high blood pressure)	
		Heart disease	
		Stroke/TIA	
		COPD	
		Ear/sinus problems	
		Muscular/skeletal condition	
		Psychiatric/psychological and emotional difficulties	
		Learning disorders (ie ADHD, ADD)	
		Bleeding disorders	
		Fainting spells	
		Thyroid disease	
		Kidney disease	
		Sickle cell disease	
		Seizures	
		Sleep disorders	
		GI problems	
		Surgery	
		Serious injury	
		Other	

Allergies or Reaction to:

Medication \_\_\_\_\_

Food, Plants, or Insect Bites \_\_\_\_\_

## Immunizations:

The following are recommended by the BSA. Tetanus immunization must have been received within the last 10 years. If had disease, put "D" and the year. If immunized, check the box and enter the year received.

YES	NO	Date	
<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	_____
<input type="checkbox"/>	<input type="checkbox"/>	Mumps	_____
<input type="checkbox"/>	<input type="checkbox"/>	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"/>	Influenza	_____

Exemption to immunizations claimed.

(For more information about immunizations, as well as the immunization exemption form, see Scouting Safety on Scouting.org.)

## MEDICATIONS

List all medications currently used. (If additional space is needed, please photocopy this part of health form.) Inhalers and EpiPen information must be included, even if they are for occasional or emergency use only.

Medication _____ Strength _____ Frequency _____ Reason for medication _____ Approximate date started _____ Temporary <input type="checkbox"/> Permanent <input type="checkbox"/>	Medication _____ Strength _____ Frequency _____ Reason for medication _____ Approximate date started _____ Temporary <input type="checkbox"/> Permanent <input type="checkbox"/>
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NOTE: Be sure to bring medications in the appropriate containers, and make sure that they are NOT expired, including inhalers and EpiPens. You SHOULD NOT STOP taking any maintenance medication.