

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

Address: _____

City: _____ State: _____

Zip+4: _____ - _____

Home Phone: (__) _____ - _____

Work Phone: (__) _____ - _____

Date of Birth: ____ \ ____ \ ____ Youth (under 21) Adult

e-mail address (only one please): _____

Occupation (adults only): _____

<http://www.siwinis.org>
email to: webmaster@siwinis.org

Siwinis Lodge # 252

Dues Payment Form

| District | Chapter: | Before Nov 1 st | After Nov 1 st | Account # |
|--------------------------------------|----------|----------------------------|---------------------------|-----------|
| <input type="checkbox"/> Frontier | Wappo | \$10 | | 082 |
| <input type="checkbox"/> North Star | Pawnee | \$10 | | 080 |
| <input type="checkbox"/> Pacifica | Lakota | \$15 | \$20 | 086 |
| <input type="checkbox"/> Rio Hondo | Wiyot | \$15 | \$25 | 084 |
| <input type="checkbox"/> San Antonio | Serrano | \$10 | \$17 | 081 |
| <input type="checkbox"/> Thunderbird | Hopi | \$10 | | 087 |

Please check one - must be registered with one chapter.

Ordeal ____ \ ____ \ ____

Troop# _____ Brotherhood ____ \ ____ \ ____

Vigil ____ \ ____ \ ____

**Mail To: Los Angeles Area Council
Order of the Arrow - Siwinis Lodge
2333 Scout Way
Los Angeles, Ca 90026-4995**

Make checks payable to:
Boy Scouts of America, OA

btw 10/01/05

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
- Fainting spells
- Diabetes
- Bleeding disorders
- Sleep walking

If yes, explain _____

None of the above applies

Any condition now requiring medication? Yes 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? Yes 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: (__) _____ - _____