

Frontier America

WILD WILD WEST

Monday June 16- Friday June 21, 2008

5:30 - 9:00 p.m.

*Early Bird Camp Discount Fees- \$35.00 (ends April 26)\$ _____
(Early Bird registration guarantees t- shirt availability)

Cub Scout Regular Fees- \$60.00 (ends June 1) \$ _____

Cub Scout Late Fees- \$80.00 (after June 1) \$ _____
(T-Shirt will not be provided. Must wear Class A shirt. No exceptions.)

Wee Camper T-shirt- \$15.00 \$ _____
(Adult Staff application MUST accompany Wee Camper registration)

A camp t-shirt will be provided for each registered staff member. Please indicate size below.

T-Shirt Orders

Camp T-shirts are required to be worn each day. If Camp T-shirt is not available, Class A shirt is REQUIRED!

Youth t-shirt sizes:

(Early Bird registration guarantees t- shirt availability)

___ YS ___ YM ___ YL ___ AS ___ AM ___ AL ___ AXL ___ AXXL

Adult t-shirt sizes:

___ S ___ M ___ L ___ XL ___ 2X ___ 3XL ___ 4XL

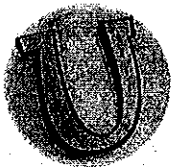
Wee Camper t-shirt sizes:

___ YS ___ YM ___ YL ___ AS ___ AM ___ AL

TOTAL:\$ _____

Make check payable to B.S.A. and send to:

Ouachita Area Council
102 Chippewa Court
Hot Springs, AR 71901
501-623-6601



YOUTH

Registration and Health Form (Adults, please use Adult Form)

U Please fill out a separate form for each camper U

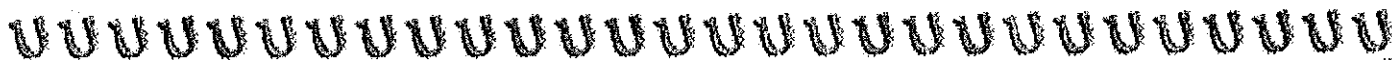
Cub Scout: _____ Pack: _____ Wee Camper: _____ (3 yrs and older)
Grade next school term: _____ Age: _____ Birth date: _____

Name: _____ Phone #: _____

Parent's Names: _____

Address: _____

City/State: _____ Zip: _____ Pack #: _____



Are there any restrictions on who can pick up the camper? Y N

If Yes, please explain: _____



In case of Emergency, Notify:

Name: _____ Phone #: _____ Alternate Phone #: _____

Address: _____

Insurance Company: _____ Policy Holder: _____ Policy Number: _____

Family Physician: _____ Phone #: _____

Health History:

Have or are subject to: Asthma Heart Problems Convulsions Fainting Allergies
 Diabetes

Sports Restrictions: _____

Other: _____

Does your child have ANY food Allergies? Yes No

Please Explain: _____

Has difficulty with: Eyes Ears Nose Throat Lungs Digestion Other: _____

Any Conditions currently taking medications for: _____

If yes, will medication be with camper? _____ Name of medication: _____

Name of prescribing Physician? _____ Phone #: _____

This health history is correct so far as I know and the person herein described has permission to engage in all activities, except as noted by me. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the adult leader in charge to hospitalize, secure proper anesthesia, and to order injections for my child. I authorize the camp medical insurance carrier to make necessary payments directly to physician or hospitals for such treatment.

Signature _____ Date _____
(Parent or Guardian)