

2009 S-8 Conclave

"Theme"

Camp Rockefeller, Gus Blass SR, Damascus, AR
April 24-26, 2009

Participant Registration & Medical Release Form Wazhazee Lodge 366

Must be received (including payment and required signatures) by Ouachita Area Council by April 14, 2009.

Name: _____ Chapter: _____
Address: _____ Tele: _____ Date of Birth: _____
City, State, Zip: _____ Email: _____

Check Applicable Blocks: Ordeal Brotherhood Vigil Youth <18 Youth 18-20 Adult 21 & Over

Conclave Registration Fee

- Earlybird Fee - \$25.00 (if paid before March 19, 2009)
 Full Conclave Fee - \$35.00 (March 19 through April 14, 2009)
 Late Registration Fee - \$50.00 (if paid after April 14, 2009)

**Registration after the April 14
deadline will cost \$50.00!**

***Participants must provide their
own bedding. Tents will be
provided by the Camp.***

Total Enclosed (Make checks payable to BSA or your local council) \$ _____

Council Accounting Code –

*Attendance and participation in Section 8 Conclave events and activities are reserved only for
members of the Lodges of Section 8 in good standing and invited guests of Section 8. Invited guests
must be approved at least 2 weeks prior to the event by the Section Key Three.*

Medical Treatment Release

In case of emergency, I understand that every effort will be made to contact me (if participant is a youth member) or the contact person (if participant is an adult) listed below. I have listed any specific dietary or physical needs on the reverse of this form. In the event the below designated individual can not be reached, I hereby give my permission to the physician selected by the adult leader in charge to secure treatment including hospitalization, anesthesia, surgery, or injections of medication for the individual above registered.

_____	_____	_____
Date	Signature of Participant	Signature of Parent or Legal Guardian if participant is under 21
_____	_____	_____
Contact Person's Name (Please Print)	Relationship	Telephone
_____	_____	_____
Address of Contact Person		
_____	_____	_____
Name of Personal Physician	Physician's Address	Physician's Telephone
_____	_____	_____
Name of Personal Health/Accident Insurance Carrier		Policy/Group Number

Send completed form and payment to:

Check Visa MasterCard

**S-8 2009 OA Conclave Registration
Ouachita Area Council #14
102 Chippewa Court
Hot Springs, Arkansas 71901**

Card Number / Exp. Date

Name on Card (Print)

Authorized Signature