

Registration Renewal Form for 2009-2010 – Cub Scout Pack 17, Wilton, CT

Annual dues for Scouting this year is **\$65.00** for each Cub Scout in our Pack and includes a subscription to Boys' Life Magazine. **Please make check payable to "PACK 17" and mail to Viv Stewart, 175 Wolfpit Road.**

Scout's Last Name	Scout's First Name and Middle Initial	Grade	Date of Birth (mm/dd/yyyy)
Address		Home Telephone #	Den #
Father's Name		Mother's Name	
Father's Work #		Mother's Work #	
Father's Cell Phone #		Mother's Cell Phone #	
Father's Driver's License # (Include State)	Mother's Driver's License # (Include State)	Family E-mail Address	

Motor Vehicle Tag Numbers and State Registered
(please list all motor vehicles in household for travel permit purposes)

Class 1 Personal Health History (To Be Updated Annually)

Check all items that apply, past or present, to your son's health history. Explain any "Yes" answers.

Allergies: Food, medicines, insects, plants: Yes No Explain below:

General Information: (Does your child have any of the following conditions?)

	Yes	No		Yes	No		Yes	No
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions/seizures	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Other (explain)	<input type="checkbox"/>	<input type="checkbox"/>

List any medications to be taken:

List any physical or behavioral conditions that may affect or limit full participation in swimming, backpacking, hiking long distances, or playing strenuous physical games:

List equipment needed such as wheelchair, braces, glasses, contact lenses, etc.:

Immunizations (give date of last inoculation):

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

Name of personal physician: _____ Telephone: _____

Personal health/accident insurance carrier: _____ Policy no. _____

Parental Authorization

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 illness or accident in the course of such activity, I request that measures be instituted without delay as the judgment of medical personnel dictates.

Signature: _____ Date: _____
(Parent or legal guardian)

A copy of this form will be made and forwarded to your Den Leader for the Den's records.