



# BARBADOS BOY SCOUTS ASSOCIATION

## NORTHERN DISTRICT SCOUT COUNCIL

### DISTRICT ACTIVITIES - YOUTH REGISTRATION FORM

FULL NAME: .....

DATE OF BIRTH: ..... RELIGION: ..... GROUP: .....

#### PARENTS/GUARDIANS

In case of emergency, please contact:

NAME: ..... TEL.#: ..... (H) ..... (W)

ADDRESS: ..... (C)

NAME: ..... TEL.#: ..... (H) ..... (W)

ADDRESS: ..... (C)

#### MEDICAL INFORMATION

Does your son/ward have or is subject to: *(Please circle Yes or No for each of the following medical conditions)*

ALLERGIES:    YES/NO FOOD            YES/NO INSECT BITES            YES/NO MEDICINES            YES/NO PLANTS

If Yes, Details: .....

YES/NO ASTHMA	YES/NO ADHD (ATTENTION DEFICIT HYPERACTIVITY DISORDER)	YES/NO BLEEDING DISORDERS
YES/NO BRONCHITIS	YES/NO CONSTIPATION	YES/NO CONVULSIONS/SEIZURES
YES/NO DIABETES	YES/NO EPILEPSY	YES/NO FAINTING SPELLS
YES/NO HEADACHES/MIGRAINE	YES/NO HEART TROUBLE	YES/NO HIGH BLOOD PRESSURE
YES/NO KIDNEY DISEASE	YES/NO MOTION SICKNESS	YES/NO NERVOUS CONDITION
YES/NO SICKLE CELL DISEASE	YES/NO SLEEPWALKING	YES/NO OTHER

If Yes, Details: .....

Is he under medical care or taking medication? ..... Details: .....

Date of last Tetanus Shot: ..... Blood Group: .....

Is he covered by Medical Insurance? ..... Details: .....

#### PARENTAL PERMISSION

I, ....., give permission for my son/ward, ....., to attend the ..... at ..... from ..... to .....

In case of emergency, I understand every effort will be made to contact me, or other named emergency contact person. In the event neither can be reached, I hereby give my permission to the licensed Medical Practitioner selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, and/or injections of medication for my son/ward.

.....  
Parent/Guardian

.....  
Date