



Delegate Registration Form (v2)

Lodge # 117

Delegate Information			
Name:			
Chapter:			
Email:	Phone:		
Address:			
City:	State:	Zip:	
Birthdate (MM/DD/YYYY):			
Circle One:	Ordeal	Brotherhood	Vigil
Special Dietary Needs:			

MAKE CHECKS PAYABLE TO: East Carolina Council

RETURN COMPLETED FORMS AND PAYMENT TO:

Scott Byrum
Lodge Adviser
204 Porter St
Tarboro, NC 27886

Registration Deadline: March 9, 2008

Registration Fee: \$35.00



Delegate Medical Form

Lodge # 117

To be filled out by parent/guardian or adult participant. Please print in ink.		
Delegate Information		
Name:	Email:	
Address:		
City:	State:	Zip Code:
Phone: ()		Date of Birth:
Circle One:	Ordeal	Brotherhood Vigil
Primary Emergency Contact		
Name:	Relationship:	
Day Phone: ()	Night Phone: ()	
Secondary Emergency Contact		
Name:	Relationship:	
Day Phone: ()	Night Phone: ()	
Medical Information		
Do you: <input type="checkbox"/> have any medical restrictions? <input type="checkbox"/> currently take any medication? <input type="checkbox"/> have any dietary restrictions?	Explain:	
Health Insurance Company:	Policy #:	
Have or subject to: <input type="checkbox"/> Convulsions <input type="checkbox"/> Asthma <input type="checkbox"/> Fainting Spells <input type="checkbox"/> Bleeding disorder <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart trouble <input type="checkbox"/> Allergy to medication, food plant, animal, or insect <input type="checkbox"/> Any condition requires special care, medication, or diet <input type="checkbox"/> NONE OF THE ABOVE APPLY	Explain:	
Have difficulty with (check if yes): <input type="checkbox"/> Eyes, ears, nose, throat <input type="checkbox"/> Digestion <input type="checkbox"/> Bed-wetting <input type="checkbox"/> Lungs <input type="checkbox"/> Sleepwalking <input type="checkbox"/> Any condition now requiring regular medication?	Explain:	
Last Tetanus toxoid date:		
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. In the event that 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, or to		
Participant		Parent or guardian
Signature:	Signature (if participant under 18 years):	
x _____ Date: _____	x _____ Date: _____	