

WHEN PIGS FLY

BSA Camporee 2015
September 25 – 27 2015
Camp Tamarancho



“When Pigs Fly Camporee” is an event where Scouts will put their Scout Skills to use while having a fun-filled, pig packed day.

Patrols will compete for top PIGS in activities such as

Flying Pigs Tournament
Boar Me with the Details – First Aid
Hog Tied – Lashings
Steal the Bacon – Team Building
Bacon Surprise – Surprise
Track the Pig – Orienteering
Clean the Bacon – Tomahawk
Snag the Tail – Archery
Boar Hunt – Rifle
And more to come...

- Cost is \$10 each person attending the event.
- Each Troop may register no more than 2 patrols of 8 Scouts.
- Registration is not complete until all forms and payment is received at Council office no later than Friday, Sept. 18, 2015. We will not register any unit at the event. Don't forget to do a Tour plan.
- Anyone coming must submit a current Part A & B Medical Form – found below.
- Any youth participating in Shooting Sports games must provide a CONSENT FOR MINOR – found below.
- Check-in at Murray Lodge starting at 5pm on Friday, September 25th with a mandatory shooting safety briefing at 8pm. Saturday will be events morning & afternoon – evening campfire – awards – night games. Check-out is Sunday after Scouts Own.
- Troops will be assigned a campsite and Scouts should hike their gear in. One car will be allowed to take Troop gear to the site after checking in and return to the parking lot.
- Leader Guide will be available August 22nd at [boyscouts-marin.org / events / camporee](http://boyscouts-marin.org/events/camporee).
- There will be a separate Dutch Oven competition – awarded by 1st – 2nd – 3rd place ribbons

Adult Advent Advisors

Jesse Barnett & Leigh Ann Bostian / camporee35@gmail.com

Unit Registration

When Pigs Fly Camporee 2015

Please fill out the forms below and fax to 415-454-5511 or e-mail to camporee35@gmail.com. All participants will need a Part A & B Medical Form and Scouts will also need a Consent for Minor, all forms can be found below... Troops will need to file a Tour Permit.

Troop # 15

Adults:

Leader in Charge

Kevin Krick

Email: krick_scouting@yahoo.com

Assistants

Mike Kelemen

thekelemens@comcast.net

Patrol Name Thundercats

1. Connor Chambers - PL

2. Cleve Schneider - APL

3. Juan Pablo Izquierdo

4. Aidan Aguilar

5. Ashton Foster

6. _____

7. _____

8. _____

Patrol Name x 10

1. Paul Kelemen - PL

2. Brian Chambers - APL

3. Caleb Krick

4. Tomas Young

5. Micah Frisch

6. _____

7. _____

8. _____

Number Attending 12 @ \$10 each = \$120 TOTAL DUE

Payment Options:

1. Credit Unit Account: YES X

2. Send a check payable to
Marin Council, BSA

Attn: **When Pigs Fly Camporee 2015**
225 West End Avenue, San Rafael, CA 94901

3. Or complete credit card information below.

Credit Card Information _____ 3-Digit Security Code _____ Visa _____ MC _____

Name on Card _____ Signature _____

Card # _____ Expiration Date _____

I agree to pay for the above total fee in accordance with my credit card agreement.

Part A: Informed Consent, Release Agreement, and Authorization

A

Full name: _____
DOB: _____

High-adventure base participants:
Expedition/crew No.: _____
or staff position: _____

Informed Consent, Release Agreement, and Authorization

I understand that participation in Scouting activities involves the risk of personal injury, including death, due to the physical, mental, and emotional challenges in the activities offered. Information about those activities may be obtained from the venue, activity coordinators, or your local council. I also understand that participation in these activities is entirely voluntary and requires participants to follow instructions and abide by all applicable rules and the standards of conduct.

With appreciation of the dangers and risks associated with programs and activities, on my own behalf and/or on behalf of my child, I hereby fully and completely release and waive any and all claims for personal injury, death, or loss that may arise against the Boy Scouts of America, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with any program or activity.

I also hereby assign and grant to the local council and the Boy Scouts of America, as well as their authorized representatives, the right and permission to use and publish the photographs/film/videotapes/electronic representations and/or sound recordings made of me or my child at all Scouting activities, and I hereby release the Boy Scouts of America, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with the activity from any and all liability from such use and publication. I further authorize the reproduction, sale, copyright, exhibit, broadcast, electronic storage, and/or distribution of said photographs/film/videotapes/electronic representations and/or sound recordings without limitation at the discretion of the BSA, and I specifically waive any right to any compensation I may have for any of the foregoing.

In case of an emergency involving me or my child, I understand that efforts will be made to contact the individual listed as the emergency contact person by the medical provider and/or adult leader. In the event that this person cannot be reached, permission is hereby given to the medical provider selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for me or my child. Medical providers are authorized to disclose protected health information to the adult in charge, camp medical staff, camp management, and/or any physician or health-care provider involved in providing medical care to the participant. Protected Health Information/Confidential Health Information (PHI/CHI) under the Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. §§160.103, 164.501, etc. seq., as amended from time to time, includes examination findings, test results, and treatment provided for purposes of medical evaluation of the participant, follow-up and communication with the participant's parents or guardian, and/or determination of the participant's ability to continue in the program activities.

(If applicable) I have carefully considered the risk involved and hereby give my informed consent for my child to participate in all activities offered in the program. I further authorize the sharing of the information on this form with any BSA volunteers or professionals who need to know of medical conditions that may require special consideration in conducting Scouting activities.



NOTE: Due to the nature of programs and activities, the Boy Scouts of America and local councils cannot continually monitor compliance of program participants or any limitations imposed upon them by parents or medical providers. However, so that leaders can be as familiar as possible with any limitations, list any restrictions imposed on a child participant in connection with programs or activities below.



List participant restrictions, if any: None

I understand that, if any information I/we have provided is found to be inaccurate, it may limit and/or eliminate the opportunity for participation in any event or activity. If I am participating at Philmont, Philmont Training Center, Northern Tier, Florida Sea Base, or the Summit Bechtel Reserve, I have also read and understand the supplemental risk advisories, including height and weight requirements and restrictions, and understand that the participant will not be allowed to participate in applicable high-adventure programs if those requirements are not met. The participant has permission to engage in all high-adventure activities described, except as specifically noted by me or the health-care provider. If the participant is under the age of 18, a parent or guardian's signature is required.

Participant's signature: _____ Date: _____

Parent/guardian signature for youth: _____ Date: _____
(If participant is under the age of 18)

Second parent/guardian signature for youth: _____ Date: _____
(If required; for example, California)

Complete this section for youth participants only:

Adults Authorized to Take to and From Events:

You must designate at least one adult. Please include a telephone number.
Name: _____

Name: _____

Telephone: _____

Telephone: _____

Adults NOT Authorized to Take Youth To and From Events:

Name: _____

Name: _____

Telephone: _____

Telephone: _____



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Part B: General Information/Health History

Full name: _____
DOB: _____

High-adventure base participants:
 Expedition/crew No.: _____
 or staff position: _____

Age: _____ Gender: _____ Height (inches): _____ Weight (lbs.): _____
 Address: _____
 City: _____ State: _____ ZIP code: _____ Telephone: _____
 Unit leader: _____ Mobilephone: _____
 Council Name/No.: _____ Unit No.: _____
 Health/Accident Insurance Company: _____ Policy No.: _____



Please attach a photocopy of both sides of the insurance card. If you do not have medical insurance, enter "none" above.



In case of emergency, notify the person below:

Name: _____ Relationship: _____
 Address: _____ Home phone: _____ Other phone: _____
 Alternate contact name: _____ Alternate's phone: _____

Health History

Do you currently have or have you ever been treated for any of the following?

Yes	No	Condition	Explain
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	Last HbA1c percentage and date:
<input type="checkbox"/>	<input type="checkbox"/>	Hypertension (high blood pressure)	
<input type="checkbox"/>	<input type="checkbox"/>	Adult or congenital heart disease/heart attack/chest pain (angina)/heart murmur/coronary artery disease. Any heart surgery or procedure. Explain all "yes" answers.	
<input type="checkbox"/>	<input type="checkbox"/>	Family history of heart disease or any sudden heart-related death of a family member before age 50.	
<input type="checkbox"/>	<input type="checkbox"/>	Stroke/TIA	
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	Last attack date:
<input type="checkbox"/>	<input type="checkbox"/>	Lung/respiratory disease	
<input type="checkbox"/>	<input type="checkbox"/>	COPD	
<input type="checkbox"/>	<input type="checkbox"/>	Ear/eyes/nose/sinus problems	
<input type="checkbox"/>	<input type="checkbox"/>	Muscular/skeletal condition/muscle or bone issues	
<input type="checkbox"/>	<input type="checkbox"/>	Head injury/concussion	
<input type="checkbox"/>	<input type="checkbox"/>	Altitude sickness	
<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric/psychological or emotional difficulties	
<input type="checkbox"/>	<input type="checkbox"/>	Behavioral/neurological disorders	
<input type="checkbox"/>	<input type="checkbox"/>	Blood disorders/sickle cell disease	
<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells and dizziness	
<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	
<input type="checkbox"/>	<input type="checkbox"/>	Seizures	Last seizure date:
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal/stomach/digestive problems	
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	
<input type="checkbox"/>	<input type="checkbox"/>	Excessive fatigue	
<input type="checkbox"/>	<input type="checkbox"/>	Obstructive sleep apnea/sleep disorders	CPAP: Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	List all surgeries and hospitalizations	Last surgery date:
<input type="checkbox"/>	<input type="checkbox"/>	List any other medical conditions not covered above	



Part B: General Information/Health History

Full name: _____

DOB: _____

High-adventure base participants:

Expedition/crew No.: _____
or staff position: _____

Allergies/Medications

Are you allergic to or do you have any adverse reaction to any of the following?

Yes	No	Allergies or Reactions	Explain	Yes	No	Allergies or Reactions	Explain
<input type="checkbox"/>	<input type="checkbox"/>	Medication		<input type="checkbox"/>	<input type="checkbox"/>	Plants	
<input type="checkbox"/>	<input type="checkbox"/>	Food		<input type="checkbox"/>	<input type="checkbox"/>	Insect bites/stings	

List all medications currently used, including any over-the-counter medications.

CHECK HERE IF NO MEDICATIONS ARE ROUTINELY TAKEN.

IF ADDITIONAL SPACE IS NEEDED, PLEASE INDICATE ON A SEPARATE SHEET AND ATTACH.

Medication	Dose	Frequency	Reason

YES NO Non-prescription medication administration is authorized with these exceptions: _____

Administration of the above medications is approved for youth by:

Parent/guardian signature

MD/DO, NP, or PA signature (if your state requires signature)



Bring enough medications in sufficient quantities and in the original containers. Make sure that they are NOT expired, including inhalers and EpiPens. You SHOULD NOT STOP taking any maintenance medication unless instructed to do so by your doctor.



Immunization

The following immunizations are recommended by the BSA. Tetanus immunization is required and must have been received within the last 10 years. If you had the disease, check the disease column and list the date. If immunized, check yes and provide the year received.

Yes	No	Had Disease	Immunization	Date(s)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tetanus	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pertussis	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diphtheria	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Measles/mumps/rubella	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Polio	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Meningitis	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Influenza	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (i.e., HIB)	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exemption to immunizations (form required)	

Please list any additional information about your medical history:

DO NOT WRITE IN THIS BOX

Review for camp or special activity.

Reviewed by: _____

Date: _____

Further approval required: Yes No

Reason: _____

Approved by: _____

Date: _____





PARENT/GUARDIAN AUTHORIZATION FORM
CONSENT FOR MINOR TO USE ARCHERY EQUIPMENT, BB*
GUNS, PELLET GUNS, OR .22 RIFLES
***Cub Scouts are only allowed to use BB GUNS**

Unit #: _____ Type: _____ Council: _____ District: _____
(Pack, Troop, Crew, Post)

Youth Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone (1): _____ Phone (2): _____
(home, cell, work) (home, cell, work)

Second mailing address: _____
(if applicable)

City: _____ State: _____ Zip Code: _____

We, the undersigned parent or legal guardian of: _____, a minor, do hereby authorize Marin Council, BSA to furnish archery equipment, BB Guns, Pellet Guns, or .22 Rifles as appropriate, to the minor named herein for the purpose of instruction in the safe handling and shooting of firearms, target shooting, and related activities under the supervision of the Shooting Sports Director and range staff. This authorization will remain in effect for said minor while he is participating in any Boy Scouts of America program or activity related to firearms/archery, unless revoked in writing by the undersigned and said revocation personally delivered to the Marin Council service center.

Parent/Guardian's Name: _____ Date: _____

Parent/Guardian's Signature: _____

BB guns and archery equipment are used by Cub Scouts at council- or district-sponsored events only.