



# APPLICATION FOR MEMBERSHIP

## BP SERVICE ASSOCIATION (BPSA)

### PLEASE PRINT

New Member [ ]

Returning Member [ ]

I would like my son/daughter/ward registered as:

Otter (5-7) [ ] Timber Wolf (8-10) [ ] Explorer (11-15) [ ] Senior Explorer (15-17) [ ] Rover (17+) [ ]

The annual fee of \$\_\_\_\_\_ is enclosed: Cash [ ] Cheque [ ] Payment received by: \_\_\_\_\_

Full Name of Youth is: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Mother's Name: \_\_\_\_\_

Please complete if applicable:

Father's Partner's Name: \_\_\_\_\_ Mother's Partner's Name: \_\_\_\_\_

Street and Mailing Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone No. \_\_\_\_\_ Cell No. \_\_\_\_\_ Email: \_\_\_\_\_

Facebook Messenger: \_\_\_\_\_ Email: \_\_\_\_\_

I agree to receive emails and messages from BPSA and acknowledge that my email address and/or Facebook Messenger will not be knowingly shared beyond the BP Service Association.

I grant permission for my son/daughter/ward to be a member in the BP Service Association and to participate fully in all activities.

I hereby grant the BP Service Association permission to use my and/or my child's image in all publications, both print and electronic, and display on the Association's websites. I also give permission for the BP Service Association to give this image to a reputable third party, when requested, for both print and electronic publications.

Yes [ ] No [ ]

I certify that my son/daughter/ward is in good health and physical condition:

Yes [ ] No [ ] (see medical form on reverse)

Are there any medical, dietary, family circumstances, custody issues or religious requirements of which the leader should be aware? YES [ ] NO [ ] (If yes, the leader will arrange a confidential private interview.)

Signature of Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Rovers over the age of 18 do not require a parent's signature, but must sign the form themselves.

## PLEASE COMPLETE MEDICAL INFO ON THE REVERSE



### MEDICAL INFORMATION



(Your child's health is important to us and this will help us if there is anything we need to know about them.)  
(Please complete fully, this page may be photocopied and kept separate from the application form on the other side.)

Surname		Given Names		Home Phone	
Group Name				Cell Phone	
Medical Plan Number		Birth Date		<input type="checkbox"/> Care Card <input type="checkbox"/> Other	
In case of emergency, please notify:					
Parent Name:			Home Phone:		Other Phone:
Other Name:			Home Phone:		Other Phone:

**IF SUBJECT TO ANY OF THE FOLLOWING PLEASE INDICATE:**

- |                                      |   |                                       |                                       |
|--------------------------------------|---|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Asthma      | <input type="checkbox"/> Cramps         | <input type="checkbox"/> Headaches    | <input type="checkbox"/> Toothache    |
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Fainting       | <input type="checkbox"/> Nightmares   | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Bronchitis  | <input type="checkbox"/> Food allergies | <input type="checkbox"/> Skin Rash    | _____                                 |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hay Fever      | <input type="checkbox"/> Sleepwalking | _____                                 |

**PRESCRIPTION OR REGULAR MEDICATIONS REQUIRED:**

Non-Prescription  Prescription  Injection

Name of Drug:	Frequency:	Dosage:	<input type="checkbox"/> Refrigeration?
Name of Drug:	Frequency:	Dosage:	<input type="checkbox"/> Refrigeration?

All prescription medication to be taken while in camp must:  
1) Be accompanied by a complete medication card.  
2) Be in the original pharmacy container and labeled with pharmacy and doctor information.

List Allergies or Sensitivities:

Date of last Tetanus Shot: \_\_\_\_\_ Date of last Medical Exam: \_\_\_\_\_

Name of Family Doctor: \_\_\_\_\_ Doctor's Phone #: \_\_\_\_\_

**Non-Prescription Drugs:** Every care and attention will be given to the health and comfort of your child. As your child may be away from home for more than 24 hours, please circle **yes/no** for the following medications that you **APPROVE/DISAPPROVE** that can be administered to your child under the guidance of an adult First Aider.

These are the medications that may be available at camps, in the event of medical necessity:

Junior Strength Acetaminophen—yes/no	Children's Benadryl—yes/no	Kid's Hurt-Free Polysporin—yes/no
Junior Strength Ibuprofen—yes/no	Gravol Kids—yes/no	Children's Antihistamine—yes/no

I, \_\_\_\_\_ am the parent and/or legal guardian of \_\_\_\_\_.  
I do hereby authorize the BP Service Association to share the medical and personal information contained in this medical information form and to provide first aid and/or secure such medical advice and services (ex: ambulance) as may be deemed necessary for the health and safety of my child/ward and hereby give my permission for my child/ward to attend and participate in all BPSA activities. I understand that I will be notified by the quickest means possible if this authority is exercised.

Signature of Parent/Guardian \_\_\_\_\_ Date Signed \_\_\_\_\_