



Camp Ammon

Boy Scouts of America
Serving the State of Wisconsin Since 1933

August 5th thru August 17th

**“WOW! A 12-day scout camp for *FIFTY-FIVE BUCKS!* (That’s right \$55)
Who ever heard of such a thing?”**

We have, we’re CAMP AMMON – BSA. This camp is a co-ed scout camp that operates exclusively during the Wisconsin State Fair. Located in the State Fair Park, this Scout camp is a distinctive service camp that allows participants freedom, fun and opportunity to explore new friendships. Camp Ammon is sponsored by Milwaukee County Council-BSA and Wisconsin State Fair.

During your 12-day stay at Camp Ammon, you can enjoy volleyball, dances, movies, an above ground swimming pool, and computer games. Focusing on service, you will gain a unique perspective of the Wisconsin State Fair; free access to stage shows, daily fair events, interaction with fairgoers, the fair's administration and much more. The \$55.00 registration fee includes a uniform shirt, cap and all meals. Participants are assigned by groups to a veteran staff member (a Tent-leader) and housed in large “circus” type tents. (YES, the \$55.00 registration includes room & board for 12 days!)

Camp Ammon is open to all Venturers, Explorers, Boy Scouts and Girl Scouts from 13 to 18 years of age from all over the State of Wisconsin. Applications are accepted on a first come - first served basis. We look forward to having you attend our camp so don’t delay. Return your application and registration fee today! We’ll send you a confirmation letter upon acceptance of your application.

HERE IS SOME IMPORTANT INFORMATION SHOULD KNOW OF:

1. Camp Ammon "**Check-in**" is on Wednesday August 5th from 10am to 2pm. Camp will conclude on **MONDAY MORNING**, August 17th. "**Check-out**" is between 10:00am & 12 Noon.
2. Camp Ammon is a full-time activity. We regret that we will be unable to make allowances for extended and repeated “leave of absences” from Camp for athletic practices or employment requirements. **Arrangements to attend family functions and school registration must be made in writing, prior to camp.** Please attach your written request to your application.
3. You must have a current medical release, to be turned in no later than “check-in”.

Don’t delay; send in your application today! Then we’ll see YOU on Wednesday, August 5th at 10:00am!

Please note that this letter is general in nature and is based on information available at time of printing. Certain items may be subject to change. Direct any questions to the Milwaukee County Council Scout Service Center at (414) 774-1776 (Ask for Lisa). To get more information or to view our FAQ sheet, you can also visit us on-line at

www.campammon-bsa.org

Thank you for your interest; we look forward to seeing you at Camp Ammon 2009!



Camp Ammon –2009

Milwaukee County Council - Boy Scouts of America

August 5th thru August 17th

please print CLEARLY

Last Name _____ First Name _____ DOB _____ Age _____

Home Address _____ Home Phone () _____

City _____ State _____ ZIP _____ E-Mail Address _____

Male _____ Female _____ Shirt Size (men's): S M L XL _____ Year in School (as of Sept. 2009): 8th FR SO JR SR _____

(Female and male campers alike, please circle one based on "Men's" shirt sizes.)

OFFICE USE ONLY
DATE RECV _____
FEE PAID _____
MEDICAL: _____
NOTES: _____

SCOUTING EXPERIENCE Have you *previously* attended Camp Ammon? _____ If "yes", how many years as a "Camper"? _____

Current Registration (*circle appropriate unit*) Girl Scout Troop / Boy Scout Troop / Sea Scout Ship / Venturing / Exploring Independent Girl Scouts Check Here

Unit Number _____ Council _____ Unit Leader Signature _____

Name of your Unit Leader _____ Unit Leader Phone Number () _____

Unit or Leader Address _____ City _____ ZIP _____

PARENT/GUARDIAN INFORMATION, AUTHORIZATION, and MEDICAL RELEASE (PLEASE PRINT CLEARLY WHERE APPLICABLE)

Parents Name _____ Home Phone: () _____ Alternate Phone: () _____

(print name)

I/we hereby give permission for my son/daughter to attend **Camp Ammon - BSA**. I/we also give consent for the Camp Director, or designated staff to act in the best interest of my child in summoning medical help in the event of an emergency, to provide hospitalization, secure proper anesthesia, and to order injection or surgery for my child or ward. I have listed on the reverse side of this application, any pre-existing or known medical conditions that affect my child, and I have listed any prescribed medications that will be in my child's possession while attending camp. (NOTE: *Please complete the back of this application with the appropriate information.*)

I/we further understand that **Camp Ammon** is a full-time activity, and as such is unable to make allowances for extended and repeated "leave of absences" from the camp, including athletic practices or employment requirements. Any arrangements to attend family functions and school registration **must** be made in writing, in advance. It is understood that **PARTICIPANTS MUST BE REGISTERED SCOUTS** (BSA or GSA) to participate in Camp Ammon – BSA.

***All "Campers" are required to attend church services while attending camp. If you do not want your child to attend church services, please attach a letter to this application explaining why they should be excused.

With this application, please enclose a check or money order for \$55.00 made out to: "Milwaukee County Council - BSA acct. # - A765", and send to: "Camp Ammon, c/o Milwaukee County Council – BSA; 330 South 84th Street; Milwaukee, WI 53214"

Applicant's Signature: _____ Parent/Guardian Signature _____ Date _____

MEDICAL EMERGENCY INFORMATION (PLEASE print clearly)

Applicant's Last Name _____ First Name _____ Middle Initial _____
Age _____ DOB _____ Male ____ Female ____

EMERGENCY CONTACT INFORMATION

Name of an Emergency Contact Person if Parent is Unavailable _____
Relationship _____ HOME PHONE () _____ ALTERNATE PHONE () _____
Family Physician _____ Address _____ Phone () _____

Parents/Guardians; Please list below any pre-existing medical conditions, and allergies:

If this applicant will have any prescription medications in their possession while attending camp, please indicate the names of these medications and the dosages:

NOTE: A recent copy of BSA Class 1 and Class 2 Medical Form # 34414 **MUST** be submitted, preferably in advance, but no later than camp "Check-in" day, August 5th. Forms are available on-line at www.campammon-bsa.org or at the Milwaukee Scout Service Center.

(Final acceptance can be delayed without a current medical form on file. Class 3 / High Adventure Medical Forms are acceptable.)
Medical information on this application is intended for emergency use only and will be kept strictly confidential.



PERSONAL HEALTH AND MEDICAL RECORD

CLASS 1 AND CLASS 2

Class 1 (update annually for all participants). Activity: Day camp, overnight hike, or other programs not exceeding 72 hours, with level of activity similar to that of home or school. Medical care is readily available. Current personal health and medical summary (history) is attested by parents to be accurate. This form is filled out by all participants and is on file for easy reference.

Class 2 (required once every 36 months for all participants under 40 years of age). Activity: Resident camp or any other activity such as backpacking, tour camping, or recreational sports involving events lasting longer than 72 consecutive hours, with level of activity similar to that at home or school. Medical care is readily available.

Note: Some states require an **annual** precamp medical evaluation. Your BSA local council service center can advise you about the requirements for your state.

If your child has had a medical evaluation (**physical examination**) within the last 36 months, a copy of the results of this examination must be attached to the health history for all participants in a camping experience lasting longer than 72 consecutive hours. If a copy is not available, a physical examination (using the Class 2 section of this form) must be scheduled by a *licensed health-care practitioner. This medical evaluation (physical examination) also is required if your child is currently under medical care, takes a prescribed medication, requires a medically prescribed diet, has had an injury or illness during the past 6 months that limited activity for a week or more, has ever lost consciousness during physical activity, or has suffered a concussion from a head injury.

*Examinations conducted by licensed health-care practitioners, other than physicians, will be recognized for BSA purposes in those states where such practitioners may perform physical examinations within their legally prescribed scope of practice.

THIS FORM IS NOT TO BE USED BY ADULTS OVER 40, BY HIGH-ADVENTURE PARTICIPANTS (USE FORM NO. 34412A), OR FOR NATIONAL SCOUT JAMBOREE (USE FORM NSJ-34412-97).

CLASS 1 PERSONAL HEALTH AND MEDICAL HISTORY

(To be filled out annually by all participants)

To be filled out by parent, guardian, or adult participant. Please print in ink.

IDENTIFICATION

Name _____ Date of birth _____ Age _____ Sex _____

Name of parent or guardian _____ Telephone _____

Home address _____ City _____ State _____ Zip _____

Business address _____ City _____ State _____ Zip _____

If person named above is not available in the event of an emergency, notify

Name _____ Relationship _____ Telephone _____

Name _____ Relationship _____ Telephone _____

Name of personal physician _____ Telephone _____

Personal health/accident insurance carrier _____ Policy No. _____

I give permission for full participation in BSA programs, subject to limitations noted herein.

In case of emergency, I understand every effort will be made to contact me (if participant is an adult, my spouse or next of kin). In the event I cannot be reached, I hereby give my permission to the licensed health-care practitioner selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child (or for me, if participant is an adult).

Date _____ Signature of parent/guardian or adult _____

Some hospitals require the parent/guardian signature to be notarized. Check with your BSA local council.

NAME

TROOP

CAMPSITE

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

ALLERGIES: Food, medicines, insects, plants Yes No Explain: _____

GENERAL INFORMATION:		Yes	No		Yes	No		Yes	No	
ADHD (Attention-Deficit)										
Hyperactivity Disorder	<input type="checkbox"/>	<input type="checkbox"/>		Convulsions/seizures	<input type="checkbox"/>	<input type="checkbox"/>		Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>		Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/leukemia	<input type="checkbox"/>	<input type="checkbox"/>		Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>		Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>

Explain: _____

Please list ALL medications taken in the 30 days **prior** to arrival at the Scouting activity where this form is to be used: _____

List any medications to be taken at camp: _____

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 _____	Measles _____	Polio _____
Diphtheria _____	Mumps _____	_____
Pertussis _____	Rubella _____	_____

CLASS 2 MEDICAL EVALUATION

(Read additional requirements outlined on front of form.)

Name _____ Age _____

NOTE TO LICENSED HEALTH-CARE PRACTITIONERS*: The person being evaluated will be attending one or more weeks of camp that may include sleeping on the ground and participating in strenuous activities such as hiking, boating, and vigorous group games. Please review the health history with the participant for any interim changes. **Explain any "abnormal" evaluations.**

PHYSICAL EXAMINATION (To be filled out by a licensed health-care practitioner*)

Height _____ Weight _____ BP _____ / _____ Pulse _____

VISION: Normal _____ Glasses _____ Contacts _____

HEARING: Normal _____ Abnormal _____ Explain _____

Check box:	N	Abn		N	Abn		N	Abn
Growth development	<input type="checkbox"/>	<input type="checkbox"/>	Teeth	<input type="checkbox"/>	<input type="checkbox"/>	Genitalia	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>	Cardiopulmonary system	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>
HEENT	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Neurobehavioral	<input type="checkbox"/>	<input type="checkbox"/>

Explain: _____

Limitations

Activity restrictions _____

Diet restrictions _____

Signature _____ Date _____

Address _____ Licensed health-care practitioner* _____ Phone _____

City, State, Zip _____

***Examinations conducted by licensed health-care practitioners, other than physicians, will be recognized for BSA purposes in those states where such practitioners may perform physical examinations within their legally prescribed scope of practice.**

INTERVAL RECORD	SCREENING EXAMINATION	
Date, Time, Place, Etc.	(Findings, diagnoses, treatment, instructions, disposition, etc.)	By
#34414A		
730176344140	PHOTOCOPYING THIS FORM IS PERMITTED.	