



# Camp Ammon

**Boy Scouts of America**  
Serving the State of Wisconsin Since 1933  
August 5<sup>th</sup> thru August 17<sup>th</sup>

January 2009

Dear Ammonite;

It's that time of year to get your application filled out and sent in to reserve your place at **Camp Ammon - 2009**. Enclosed with this cover letter is your Ammon application.

As in the past, we anticipate a waiting list to get into camp. So we're sending prior years' Campers this first special mailing to make certain that you can get registered early. Time is of the essence. Applications are accepted on a first come - first served basis. You're in the first mailing. So don't delay, send your application in today. Medical forms will be sent out with the acceptance letters shortly after we receive your application, or download a printable medical form from our website, [www.campammon-bsa.org](http://www.campammon-bsa.org). Feel free to copy your application and give it to other members of your scout unit.

**PLEASE NOTE:** Campers requesting to be considered for the position of ATL, must write the words "**ATL REQUEST**" in **RED**, at the **top left side** of the application. Attach a brief letter explaining your qualifications and reasons for your request. Personnel that held the position of ATL last year are given first preference. Positions are filled from any vacancies.

Please enclose a check/money order for **\$55.00** made out to: "Milwaukee County Council - BSA acct. # - A765", and return it to:

**Camp Ammon - Camper Applications**  
c/o Milwaukee County Council - BSA  
330 South 84<sup>th</sup> Street  
Milwaukee, WI 53214

**Eligible** campers that wish to apply for **staff** must write "**STAFF REQUEST**" in **RED** on the **TOP RIGHT** side of their camper application. **STAFF REQUESTS** and **STAFF APPLICATIONS ONLY** are to be sent to us via U.S. mail to:

Camp Ammon Staff  
c/o Michele Greenmier  
3508 East Barnard Avenue  
Cudahy, WI 53110

**\*\*DO NOT SEND STAFF APPLICATIONS TO THE SCOUT OFFICE!\*\***

**Camp Ammon "Check-in"** is on Wednesday August 5<sup>th</sup>, from 10am to 2pm. **Camp will conclude on Monday Morning, August 17<sup>th</sup>.** "Check-out" time is between 10am and 12 Noon. If necessary, earlier "Check-out" arrangements can be made. (In writing and in advance.) **Please note:** A parent (or guardian over age 21) is necessary for "Check-in" and "Check-out".

If you or your parents have any questions, call the Scout Service Center at (414) 774-1776, or email us at [ammoninfo@campammon-bsa.org](mailto:ammoninfo@campammon-bsa.org) (please write "Camp Ammon Question" on the subject line.) We will do our best to answer your questions as soon as possible.

So send in your application today. Then we'll see YOU on Wednesday, August 5<sup>th</sup> at 10am!

Sincerely,

*Sam*

Sam Santoro Jr.

*Juan*

Dr. Juan Luglio  
Directors

*Michele*

Michele Greenmier





# Camp Ammon –2009

Milwaukee County Council - Boy Scouts of America

August 5<sup>th</sup> thru August 17<sup>th</sup>

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.)

<b>OFFICE USE ONLY</b>
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 84<sup>th</sup> 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:

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

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**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 5<sup>th</sup>. Forms are available on-line at [www.campammon-bsa.org](http://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

CAMP SITE

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

**ALLERGIES:** Food, medicines, insects, plants Yes  No  Explain: \_\_\_\_\_

<b>GENERAL INFORMATION:</b>	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 \_\_\_\_\_

<b>Check box:</b>	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 \_\_\_\_\_

Licensed health-care practitioner\*

Address \_\_\_\_\_ 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.**

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