



Conclave 2010 Delegate Registration Form

Delegate Information		
Name:		
Chapter:		
Email:	Phone:	
Address:		
City:	State:	Zip:
Birthdate (MM/DD/YYYY):		
Circle One:		
Ordeal	Brotherhood	Vigil
Submission		
<p>Form due by end of Spring Pow-Wow to:</p> <p>Finance Adviser Keith Biegert 102 Bristol Hill Ct. Cary, NC 27513</p> <p>Fee: \$35</p> <p>Make checks out to Occoneechee Lodge 104.</p>		



Conclave 2010 Delegate Medical Form

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

Delegate Information

Name:		Email:	
Address:			
City:	State:	Zip Code:	Chapter:
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	Explain:
<input type="checkbox"/> Any condition now requiring regular medication?	Name of medication:
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 order injection.

Participant

Parent or guardian

Signature:	Signature (if participant under 18 years):
x _____ Date: _____	x _____ Date: _____