

Member Information					
Name:			Email:		
Address:					
City:		State:		Zip Code:	
Phone: ()		Unit Number:		Date of Birth:	
Circle Chapter: Amangi Newo (Hemlock) Canotka (Cape Fear) Eluwak (Mawat) Eno (Orange) Impeesa (Baden Powell) Kato Hochuli (Falls) Lumbee Anilorac (Kia Kima) Natisihi (Moore) Netami (Crosswinds) Neusiok (Neuse River) Niganit (Tuocs) Yamni Wakpa (Three Rivers) Wazeeyahtah (Great Northern)					
Medical Information					
Do you: ___ have any medical restrictions? ___ currently take any medication? ___ have any dietary restrictions?			Explain:		
Health Insurance Company:			Policy #:		
Have or subject to: ___ Convulsions ___ Asthma ___ Fainting Spells ___ Bleeding disorder ___ Diabetes ___ Heart Trouble ___ Allergy to medication, food plant, animal, or insect ___ Any condition requires special care, medication, or diet ___ NONE OF THE ABOVE APPLY			Explain:		
Have difficulty with (check if yes): ___ Eyes, ears, nose, throat ___ Digestion ___ Bed-wetting ___ Lungs ___ Sleepwalking			Explain:		
___ Any condition now requiring regular medication?			Name of medication:		
Date of Immunizations: Tetanus toxoid _____ Polio _____ Mumps _____ Pertussis _____ Diphtheria _____ Measles _____ Rubella _____					
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.					
Candidate			Parent or guardian		
Signature:			Signature (if candidate is under 18 years):		
x _____ Date: _____			x _____ Date: _____		
			Home Phone:		Mobile Phone: