

# 2009 S-8 Conclave

*"Theme"*

Camp Rockefeller, Gus Blass SR, Damascus, AR  
April 24-26, 2009

## Participant Registration & Medical Release Form Ta Tsu Hwa Lodge 138

*Must be received (including payment and required signatures) by Indian Nations Council by April 14, 2009.*

Name: \_\_\_\_\_ Chapter: \_\_\_\_\_

Address: \_\_\_\_\_ Tele: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Email: \_\_\_\_\_

Check Applicable Blocks:  Ordeal  Brotherhood  Vigil  Youth <18  Youth 18-20  Adult 21 & Over

### Conclave Registration Fee

- Earlybird Fee - \$25.00 (if paid before March 19, 2009)  
 Full Conclave Fee - \$35.00 (March 19 through April 14, 2009)  
 Late Registration Fee - \$50.00 (if paid after April 14, 2009)

**Registration after the April 14  
deadline will cost \$50.00!**

***Participants must provide their  
own bedding. Tents will be  
provided by the Camp.***

Total Enclosed (Make checks payable to BSA or your local council) \$ \_\_\_\_\_

**Council Accounting Code – 6014**

*Attendance and participation in Section 8 Conclave events and activities are reserved only for  
members of the Lodges of Section 8 in good standing and invited guests of Section 8. Invited guests  
must be approved at least 2 weeks prior to the event by the Section Key Three.*

## Medical Treatment Release

In case of emergency, I understand that every effort will be made to contact me (if participant is a youth member) or the contact person (if participant is an adult) listed below. I have listed any specific dietary or physical needs on the reverse of this form. In the event the below designated individual can not be reached, I hereby give my permission to the physician selected by the adult leader in charge to secure treatment including hospitalization, anesthesia, surgery, or injections of medication for the individual above registered.

_____	_____	_____
Date	Signature of Participant	Signature of Parent or Legal Guardian if participant is under 21
_____	_____	_____
Contact Person's Name (Please Print)	Relationship	Telephone
_____	_____	_____
Address of Contact Person		
_____	_____	_____
Name of Personal Physician	Physician's Address	Physician's Telephone
_____	_____	_____
Name of Personal Health/Accident Insurance Carrier		Policy/Group Number
_____		_____

Send completed form and payment to:

Check  Visa  MasterCard

**S-8 2009 OA Conclave Registration  
Indian Nations Council #488  
4295 South Garnett  
Tulsa, Oklahoma 74146**

\_\_\_\_\_  
Card Number

\_\_\_\_\_  
Exp. Date

\_\_\_\_\_  
Name on Card (Print)

\_\_\_\_\_  
Authorized Signature