



WEBELOS ADVENTURE CAMP

Belk Scout Camp

2023

Session 1: Thursday, July 13th through Sunday, July 16th

Session 2: Sunday, July 16th through Wednesday, July 19th

Session 3: Thursday, July 20th through Sunday, July 23rd





Introductions

- Camp Director: Sasha Timkovich
- Program Director: Tim Lamb
- Senior Patrol Leader: Jasmin Chadwick
- Advisor: Kim Morrison





Welcome!

- Webelos Adventure Camp (WAC) is held at Belk Scout Camp in Midland, NC.
- Each session will officially open on Day 1 with afternoon check-in and close on Day 4 at 10:00 AM after the closing ceremony, completion of duty assignments, campsite cleanup and inspection.
- Visit the WAC Website for important information.
<https://www.mccscouting.org/webelosadventurecamp>
- Please make sure we have accurate and up to date contact information for each unit.





BSA Medical Forms For **CUB SCOUTS**

The Scouting adventure, camping trips, high-adventure excursions, and having fun are important to everyone in Scouting—and so is your safety and well-being. Completing the Annual Health and Medical Record is the first step in making sure you have a great Scouting experience.



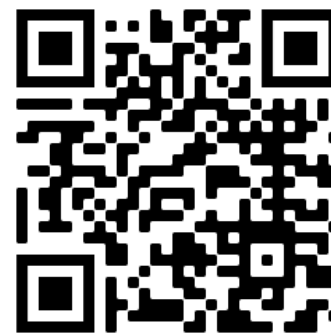
So, what do you need?





Annual Health and Medical Record

- Current 2019 BSA Health Forms may be found at <https://www.scouting.org/health-and-safety/ahmr/>
- Part A & B of the health form applies to ALL participants—in basic Scouting activities such as local tours and weekend camping trips less than 72 hours in duration.
- Part C – a pre-participation physical, is required for events that are 72 hours or longer in duration.



Completing Part A

Full name: _____


DOB: _____

Ensure Full Name and Date of Birth are listed.

Notice section regarding BB guns.

I give permission for my child to use a BB device. (Note: Not all events will include BB devices.)

Checking this box indicates you DO NOT want your child to use a BB device.



NOTE: Due to the nature of programs and activities, the Boy Scouts of America and local councils cannot continually monitor compliance of program participants or any limitations imposed upon them by parents or medical providers. However, so that leaders can be as familiar as possible with any limitations, list any restrictions imposed on a child participant in connection with programs or activities below.

List participant restrictions, if any: None



Part A: Informed Consent, Release Agreement, and Authorization

Full name: _____ High adventure travel certificate: _____
 State of birth: _____ Participant: _____

BB Gun Permission

I give permission for my child to use a BB device. (Note: Not all events will include BB devices.)

Checking this box indicates you DO NOT want your child to use a BB device.

Participant Restrictions

List participant restrictions, if any: None

Restrictions should be listed. Otherwise “None” should be checked by the participant (or parent/guardian).



Completing Part A

I understand that, if any information I/we have provided is found to be inaccurate, it may limit and/or eliminate the opportunity for participation in any event or activity. If I am participating at Pleasant Scout Ranch, Pleasant Training Center, Northern Tier, Sea Base, or the Summit Bechtel Reserve, I have also read and understand the supplemental risk advisories, including height and weight requirements and restrictions, and understand that the participant will not be allowed to participate in applicable high-adventure programs if those requirements are not met. The participant has permission to engage in all high-adventure activities described, except as specifically noted by me or the health-care provider; if the participant is under the age of 18, a parent or guardian's signature is required.

Participant's signature: _____ Date: _____

Parent/guardian signature for youth: _____ Date: _____

(If participant is under the age of 18)

- Participant over the age of 18 - sign and date the TOP line.
- Parent/guardian sign and date the BOTTOM line for participants less than 18 years. No signature = No participation
- Date MUST be within the last 12 months.

Part A: Informed Consent, Release Agreement, and Authorization

Full name: _____ High-adventure activities: _____
 Date of birth: _____ Experience: _____
 Experience: _____

Release/Consent, Release Agreement, and Authorization

I understand the participant is/are participating in the high-adventure program described above, and I/we understand the supplemental risk advisories, including height and weight requirements and restrictions, and understand that the participant will not be allowed to participate in applicable high-adventure programs if those requirements are not met. The participant has permission to engage in all high-adventure activities described, except as specifically noted by me or the health-care provider; if the participant is under the age of 18, a parent or guardian's signature is required.

I/we understand that, if any information I/we have provided is found to be inaccurate, it may limit and/or eliminate the opportunity for participation in any event or activity. If I am participating at Pleasant Scout Ranch, Pleasant Training Center, Northern Tier, Sea Base, or the Summit Bechtel Reserve, I have also read and understand the supplemental risk advisories, including height and weight requirements and restrictions, and understand that the participant will not be allowed to participate in applicable high-adventure programs if those requirements are not met. The participant has permission to engage in all high-adventure activities described, except as specifically noted by me or the health-care provider; if the participant is under the age of 18, a parent or guardian's signature is required.

I/we understand that, if any information I/we have provided is found to be inaccurate, it may limit and/or eliminate the opportunity for participation in any event or activity. If I am participating at Pleasant Scout Ranch, Pleasant Training Center, Northern Tier, Sea Base, or the Summit Bechtel Reserve, I have also read and understand the supplemental risk advisories, including height and weight requirements and restrictions, and understand that the participant will not be allowed to participate in applicable high-adventure programs if those requirements are not met. The participant has permission to engage in all high-adventure activities described, except as specifically noted by me or the health-care provider; if the participant is under the age of 18, a parent or guardian's signature is required.

Participant's signature: _____ Date: _____

Parent/guardian signature for youth: _____ Date: _____

(If participant is under the age of 18)

Complete this section for youth participants only:

Adults Authorized to Take Youth to and From Events:

You must designate at least one adult. Please include a phone number.

Name: _____ Phone: _____

Name: _____ Phone: _____

Adults NOT Authorized to Take Youth to and From Events:

Name: _____ Phone: _____

Name: _____ Phone: _____

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- For Minors – at least one adult authorized to pick up must be listed.
- If there are Unauthorized Adults – list here.





Completing Part B1 – Page 2

Health History

Do you currently have or have you ever been treated for any of the following?

Yes	No	Condition	Explain
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	Last HbA1c percentage and date: _____ Insulin pump: Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Hypertension (high blood pressure)	
<input type="checkbox"/>	<input type="checkbox"/>	Adult or congenital heart disease/heart attack/chest pain (anginal)/heart murmur/coronary artery disease. Any heart surgery or procedure. Explain all "yes" answers.	
<input type="checkbox"/>	<input type="checkbox"/>	Family history of heart disease or any sudden heart-related death of a family member before age 50.	
<input type="checkbox"/>	<input type="checkbox"/>	Stroke/TIA	
<input type="checkbox"/>	<input type="checkbox"/>	Asthma/reactive airway disease	Last attack date: _____
<input type="checkbox"/>	<input type="checkbox"/>	Lung/respiratory disease	
<input type="checkbox"/>	<input type="checkbox"/>	COPD	
<input type="checkbox"/>	<input type="checkbox"/>	Ear/eyes/nose/sinus problems	
<input type="checkbox"/>	<input type="checkbox"/>	Muscular/skeletal condition/muscle or bone issues	
<input type="checkbox"/>	<input type="checkbox"/>	Head injury/concussion/TBI	
<input type="checkbox"/>	<input type="checkbox"/>	Altitude sickness	
<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric/psychological or emotional difficulties	
<input type="checkbox"/>	<input type="checkbox"/>	Neurological/behavioral disorders	
<input type="checkbox"/>	<input type="checkbox"/>	Blood disorders/sickle cell disease	
<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells and dizziness	
<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	
<input type="checkbox"/>	<input type="checkbox"/>	Seizures or epilepsy	Last seizure date: _____
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal/stomach/digestive problems	
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	
<input type="checkbox"/>	<input type="checkbox"/>	Skin issues	
<input type="checkbox"/>	<input type="checkbox"/>	Obstructive sleep apnea/sleep disorders	CPAP: Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	List all surgeries and hospitalizations	Last surgery date: _____
<input type="checkbox"/>	<input type="checkbox"/>	List any other medical conditions not covered above	

Health History

“Yes” or “No” needs to be indicated for each condition.





Completing Part B2 – Page 3

Full name: _____

DOB: _____

Ensure Full name and Date of birth are listed.

Allergies/Medications

DO YOU USE AN EPINEPHRINE AUTOINJECTOR? Exp. date (if yes) YES NO

DO YOU USE AN ASTHMA RESCUE INHALER? Exp. date (if yes) YES NO

Are you allergic to or do you have any adverse reaction to any of the following?

Yes	No	Allergies or Reactions	Explain
<input type="checkbox"/>	<input type="checkbox"/>	Medication	
<input type="checkbox"/>	<input type="checkbox"/>	Food	

Yes	No	Allergies or Reactions	Explain
<input type="checkbox"/>	<input type="checkbox"/>	Plants	
<input type="checkbox"/>	<input type="checkbox"/>	Insect bites/stings	

Notice: Section about EpiPens and Asthma inhalers.

If participant has no allergies, “No” should be indicated in all 4 categories. If allergy is present, check “Yes” next to appropriate category(s) and explain the allergy/reaction.

Part B2: General Information/Health History **B2**

Full name: _____ High-adventure base participants: _____
 Date of birth: _____ (if applicable)

Allergies/Medications

DO YOU USE AN EPINEPHRINE AUTOINJECTOR? Exp. date (if yes) YES NO

DO YOU USE AN ASTHMA RESCUE INHALER? Exp. date (if yes) YES NO

Please always list all you have any adverse reaction to any of the following!

Yes	No	Allergies or Reactions	Explain
<input type="checkbox"/>	<input type="checkbox"/>	Medication	
<input type="checkbox"/>	<input type="checkbox"/>	Food	
<input type="checkbox"/>	<input type="checkbox"/>	Plants	
<input type="checkbox"/>	<input type="checkbox"/>	Insect bites/stings	

List all medications currently used, including any over-the-counter medications.

Check here if no medications are routinely taken. If additional space is needed, please list on a separate sheet and attach.

Medication	Dose	Frequency	Reason

YES NO Have general medical conditions or conditions not listed here? YES NO
Indicate the date of the last medical check-up.

Immunization

The following immunizations are recommended. Please check each one and indicate when they were last received within the last 12 months. If you are unsure about the status of any of these immunizations, please consult your physician.

Yes	No	Not Entered	Immunization	Notes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tetanus	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diphtheria	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Polio	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	MM (Measles/Mumps/Rubella)	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shingles	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Adenovirus	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (List in comments)	

Complete for immunizations (Date required)

DO NOT WRITE IN THIS BOX.
 Please list any additional information about your medical history.

Signature: _____
 Date: _____
 Adult approval number: YES NO
 Signature: _____
 Date: _____

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Completing Part B2 – Page 3

If no meds are routinely taken, box should be checked. Otherwise, Medications should be listed.

List all medications currently used, including any over-the-counter medications.

Check here if no medications are routinely taken, if additional space is needed, please list on a separate sheet and attach.

Medication	Dose	Frequency	Reason

YES NO Non-prescription medication administration is authorized with these exceptions:

Administration of the above medications is approved for youth by:

Participant signature _____ MUSTEL NF or PA signature if your state requires signature

In order for Camp Health Officers to administer prescription AND/OR over the counter medications (such as Tylenol) the “YES” box needs to be checked and a parent/guardian signature must be present. Checking “No” or not signing will not exclude participant from attending. Parent/guardian will be called for all medication needs.

Part B2: General Information/Health History

Full name: _____ High-altitude base participants: _____
 Date of birth: _____

Allergies/Medications
 DO YOU USE AN EPINEPHRINE AUTOINJECTOR? Exp. date (if any) YES NO DO YOU USE AN ALTIMA INSULIN INJECTOR? Exp. date (if any) YES NO

Medications Table:

Yes	No	Allergies or Medication	Expire	Yes	No	Allergies or Medication	Expire
<input type="checkbox"/>	<input type="checkbox"/>	Aspirin		<input type="checkbox"/>	<input type="checkbox"/>	Penicillin	
<input type="checkbox"/>	<input type="checkbox"/>	Codeine		<input type="checkbox"/>	<input type="checkbox"/>	Amoxicillin	
<input type="checkbox"/>	<input type="checkbox"/>	Other		<input type="checkbox"/>	<input type="checkbox"/>	Other	

Immunization Table:

Yes	No	Not Entered	Immunization	Expiry
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diphtheria	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tetanus	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Polio	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	MM (Measles/Mumps/Rubella)	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shingles	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other	

Participant signature _____ MUSTEL NF or PA signature if your state requires signature





Completing Part B2 – Page 3

Immunization

The following immunizations are recommended. Tetanus immunization is required and must have been received within the last 10 years. If you had the disease, check the disease column and list the date. If immunized, check yes and provide the year received.

Yes	No	Had Disease	Immunization	Date(s)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tetanus	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pertussis	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diphtheria	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mumps/mumps/rubella	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Polio	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Measles	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Influenza	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (i.e., HIV)	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exemption to Immunizations (form required)	

Please list any additional information about your medical history:

DO NOT WRITE IN THIS BOX.
Reserve for camp or special activity.

Reviewed by: _____

Date: _____

Further approval required: Yes No

Reason: _____

Approved by: _____

Date: _____

Part B2: General Information/Health History **B2**

Full name: _____ High-altitude base participants: _____
 Date of birth: _____ Identification No. _____
 or last position: _____

Allergies/Medications
 DO YOU USE AN EPINEPHRINE AUTOINJECTOR? Exp. date (if any) YES NO
 DO YOU USE AN ALTIMA INSULIN INJECTOR? Exp. date (if any) YES NO

You can always list all you have any allergies reaction to any of the following!

Yes	No	Allergies or Reaction	Epineph	Yes	No	Allergies or Reaction	Epineph
<input type="checkbox"/>	<input type="checkbox"/>	Medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Food	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (specify)	<input type="checkbox"/>

List all medications currently used, including any over-the-counter medications.
 Check here if no medications are routinely taken. If additional space is needed, please list on a separate sheet and attach.

Medication	Dose	Frequency	Reason

YES NO Have general medical consultation in wilderness with these conditions
 Medication(s) of the above medication is approved for youth by: _____
Prescription medication: _____ (NADA # if required or you may leave blank)

⚠️ Bring enough medication to sufficient quantities and in the proper container. Please note that they are NOT approved, including insulin and caffeine. You SHOULD NOT STOP taking any medications unless you are instructed to do so by your doctor.

Immunization

The following immunizations are recommended. Tetanus immunization is required and must have been received within the last 10 years. If you had the disease, check the disease column and list the date. If immunized, check yes and provide the year received.

Yes	No	Had Disease	Immunization	Date(s)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tetanus	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pertussis	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diphtheria	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mumps/mumps/rubella	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Polio	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Measles	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Influenza	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (i.e., HIV)	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exemption to Immunizations (form required)	

Please list any additional information about your medical history:

DO NOT WRITE IN THIS BOX.
Reserve for camp or special activity.

Reviewed by: _____

Date: _____

Further approval required: Yes No

Reason: _____

Approved by: _____

Date: _____

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2011 Printing

- It is BSA policy that participants have a tetanus immunization that has been administered within the last 10 years. The date of the most recent tetanus shot **MUST** be listed. Participants may **NOT** attend camp without this immunization.
- Special considerations will be given to those with religious, philosophical, or medical requests for exemption. The BSA Immunization Request for Exemption must be completed and attached. <https://filestore.scouting.org/filestore/pdf/680-451.pdf>





Completing Part B2 – Page 3

Immunization

The following immunizations are recommended. Tetanus immunization is required and must have been received within the last 10 years. If you had the disease, check the disease column and list the date. If immunized, check yes and provide the year received.

Yes	No	Had Disease	Immunization	Date(s)
<input type="checkbox"/>	<input type="checkbox"/>		Tetanus	
<input type="checkbox"/>	<input type="checkbox"/>		Pertussis	
<input type="checkbox"/>	<input type="checkbox"/>		Diphtheria	
<input type="checkbox"/>	<input type="checkbox"/>		Mumps/rubella/zoster	
<input type="checkbox"/>	<input type="checkbox"/>		Polio	
<input type="checkbox"/>	<input type="checkbox"/>		Chicken Pox	
<input type="checkbox"/>	<input type="checkbox"/>		Hepatitis A	
<input type="checkbox"/>	<input type="checkbox"/>		Hepatitis B	
<input type="checkbox"/>	<input type="checkbox"/>		Meningitis	
<input type="checkbox"/>	<input type="checkbox"/>		Influenza	
<input type="checkbox"/>	<input type="checkbox"/>		Other (i.e., HIV)	
<input type="checkbox"/>	<input type="checkbox"/>		Exemptor to Immunizations (form required)	

Please list any additional information about your medical history:

DO NOT WRITE IN THIS BOX.
Reserve for camp or special activity.

Reviewed by: _____

Date: _____

Further approval required: Yes No

Reason: _____

Approved by: _____

Date: _____

B2

Part B2: General Information/Health History

Full name: _____ High-altitude base participants: _____
 Date of birth: _____ (i.e., full postal)

Allergies/Medications
 DO YOU USE AN EPINEPHRINE AUTO-INJECTOR? Exp. date (if any) YES NO
 DO YOU USE AN ALTIMA INSULIN INJECTOR? Exp. date (if any) YES NO

You may always list all you have any allergic reaction to any of the following:

Yes	No	Allergies or Reaction	Expire	Yes	No	Allergies or Reaction	Expire
<input type="checkbox"/>	<input type="checkbox"/>	Medication		<input type="checkbox"/>	<input type="checkbox"/>	Food	
<input type="checkbox"/>	<input type="checkbox"/>	Other		<input type="checkbox"/>	<input type="checkbox"/>	Other (specify)	

List all medications currently used, including any over-the-counter medications.
 Check here if no medications are routinely taken. If additional space is needed, please list on a separate sheet and attach.

Medication	Dose	Frequency	Reason

YES NO Have general/medical administration is authorized with these conditions:
 Authorization of the above medication is approved for guest by: _____
 (Name/Signature) (Date) (If it requires a year then insert required)

⚠️ Bring enough medication to sufficient quantities and in the proper container. Please note that they are NOT approved, including insulin and caffeine. Do NOT bring any over-the-counter medication unless indicated to do so by your guide.

Immunization

The following immunizations are recommended. Tetanus immunization is required and must have been received within the last 10 years. If you had the disease, check the disease column and list the date. If immunized, check yes and provide the year received.

Yes	No	Had Disease	Immunization	Date(s)
<input type="checkbox"/>	<input type="checkbox"/>		Tetanus	
<input type="checkbox"/>	<input type="checkbox"/>		Pertussis	
<input type="checkbox"/>	<input type="checkbox"/>		Diphtheria	
<input type="checkbox"/>	<input type="checkbox"/>		Mumps/rubella/zoster	
<input type="checkbox"/>	<input type="checkbox"/>		Polio	
<input type="checkbox"/>	<input type="checkbox"/>		Chicken Pox	
<input type="checkbox"/>	<input type="checkbox"/>		Hepatitis A	
<input type="checkbox"/>	<input type="checkbox"/>		Hepatitis B	
<input type="checkbox"/>	<input type="checkbox"/>		Meningitis	
<input type="checkbox"/>	<input type="checkbox"/>		Influenza	
<input type="checkbox"/>	<input type="checkbox"/>		Other (i.e., HIV)	
<input type="checkbox"/>	<input type="checkbox"/>		Exemptor to Immunizations (Date required)	

Please list any additional information about your medical history:

DO NOT WRITE IN THIS BOX.
Reserve for camp or special activity.

Reviewed by: _____

Date: _____

Further approval required: Yes No

Reason: _____

Approved by: _____

Date: _____

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- Immunization/Disease status should be indicated for all other vaccines. Dates are preferable. Attaching an immunization record will also suffice.





Part C – Page 4

- ONLY required for events that are longer than 72 consecutive hours.
- To be completed by a certified and licensed physician (MD, DO), nurse practitioner, or physician assistant.
- Exam must have been completed within the last 12 months.
- For WAC – only required for resident staff.

Part C: Pre-Participation Physical **C**
This part must be completed by certified and licensed physicians (MD, DO), nurse practitioners, or physician assistants.

Full name: _____ High-altitude hike participant:
 Date of birth: _____ (circle initials) or (self)

⚠️ We are being asked to certify that this individual has no contraindication for participation in a training experience for volunteers who will be attending a high-altitude program, including one of the national high-altitude events, please refer to the requirements/requirements and the following pages in the form provided by your patient. You can also visit www.scouting.org/health-and-safety to read this information online.

Phase III to be following information:

Yes		No		Explain	
Medical attention to participate					
<input type="checkbox"/>	<input type="checkbox"/>				

Yes	No	Explain or Reaction	Yes	No	Explain or Reaction
<input type="checkbox"/>	<input type="checkbox"/>	Medication	<input type="checkbox"/>	<input type="checkbox"/>	Diets
<input type="checkbox"/>	<input type="checkbox"/>	Food	<input type="checkbox"/>	<input type="checkbox"/>	Recent bloodwork

Height (inches)	Weight (lbs.)	BMI	Heart Pressure	Pulse

	Normal	Abnormal	Explain Abnormalities
Color	<input type="checkbox"/>	<input type="checkbox"/>	
Constitutional	<input type="checkbox"/>	<input type="checkbox"/>	
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	
Heart	<input type="checkbox"/>	<input type="checkbox"/>	
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>	
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	

Examiner's Certification
 I certify that I have reviewed the health history and assessed the present and past contraindications for participation in a training experience. The participant will receive instructions:

Yes	No	Explain
<input type="checkbox"/>	<input type="checkbox"/>	Does not require weight management.
<input type="checkbox"/>	<input type="checkbox"/>	Has no uncontrolled heart disease, lung disease, or hypertension.
<input type="checkbox"/>	<input type="checkbox"/>	Has not had an orthopedic injury, musculoskeletal problems, or orthopedic surgery in the last six months or possesses a letter of clearance from the orthopedic surgeon or treating physician.
<input type="checkbox"/>	<input type="checkbox"/>	Has no uncontrolled psychiatric disorders.
<input type="checkbox"/>	<input type="checkbox"/>	Has not had an asthma attack in the last year.
<input type="checkbox"/>	<input type="checkbox"/>	Does not have a potentially contagious condition.
<input type="checkbox"/>	<input type="checkbox"/>	If planning to donate blood, does not have a bloodborne infection or disease.

Examiner's signature: _____ Date: _____
 Examiner's printed name: _____
 Address: _____
 City: _____ State: _____ ZIP code: _____
 Other phone: _____

Height/Weight Restrictions
If you exceed the maximum weight for height as explained in the following chart and your present high-altitude activity will take you more than 20 minutes away from an emergency medical attention facility, you may not be allowed to participate.

Height (inches)	Max. Weight	Height (inches)	Max. Weight	Height (inches)	Max. Weight	Height (inches)	Max. Weight
48	100	48	100	50	110	50	100
49	110	49	110	51	120	51	110
50	120	50	120	52	130	52	120
51	130	51	130	53	140	53	130
52	140	52	140	54	150	54	140
53	150	53	150	55	160	55	150
54	160	54	160	56	170	56	160
55	170	55	170	57	180	57	170
56	180	56	180	58	190	58	180
57	190	57	190	59	200	59	190

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Missing Info means the participant will miss the event!



- Review your roster. Do you have medical forms for ALL participants? This includes Scouts, siblings, and Adults.
- Do you have all of the pages? (Note: Part B is 2 pages)
- Is all the information filled out in entirety?
- Is there a date of the most recent tetanus shot? Is it within the last 10 years?
- Is the front and back of the insurance card copied and attached?

Ensure forms are complete, correct, and accounted for!





Program – Where the FUN Begins!

- Program Director – Tim Lamb
WACProgramDirector@gmail.com
- WAC program is Youth Lead.
- Advancement Information will be posted on the WAC website. (Available closer to the start of camp.)
- Changing Programs for 2023:
 - Retiring - Protect Yourself
 - Adding - Fishing
- Consider walking times between stations

- We need you!
- Would you like to volunteer at one of our program stations?
- Do you know someone who would like to lend a hand?





Overall Daily Schedule

Start	End	Day 1	Day 2	Day 3	Day 4	
6:30 AM			Reveille	Reveille	Reveille	
7:15 AM	7:30 AM		Flag Assembly	Flag Assembly	Flag Assembly	
7:30 AM			Breakfast	Breakfast	Breakfast	
8:30 AM	9:30 AM		Period 1	Period 1	A Scout is Reverent & Clean Up Assignments	
9:40 AM	10:40 AM		Period 2	Period 2	Check Out	
10:50 AM	11:50 AM		Period 3	Period 3		
12:00 PM	1:00 PM		Lunch	Lunch		
1:10 PM	2:10 PM		Period 4	Period 4		
2:20 PM	3:20 PM		Check-In Group 1	Period 5		Period 5
3:30 PM	4:30 PM		Check-In Group 2	Period 6		Period 6
4:40 PM	5:40 PM	Check-In Group 3	Period 7	Period 7		
6:00 PM	6:15 PM	Flag Assembly	Flag Assembly	Flag Assembly		
6:15 PM	6:50 PM	Dinner	Dinner	Dinner		
7:00 PM	8:00 PM	Leader Meeting	Period 8	Period 8		
8:00 PM	8:30 PM	Emergency Drill	Evening Program	Closing Campfire		
8:30 PM	9:30 PM	Opening Campfire				
10:30 PM		All Quiet	All Quiet	All Quiet		

- Available in the Pack Leader Guide posted to the WAC website.





Unit Registration and Planning

- Unit registration will open March 1st
- For the first step of registration, you will:
 - Pick the session you want to attend
 - Select your preferred check-in time (2:20, 3:30, or 4:40)
 - Choose your campsite preference
 - List all the names of the adults then the youth (w/ gender & age)
 - You must have 2 adults on the roster before you may add scouts.
 - List everyone's T-shirt size and food allergy information
 - Whether to separate the Webelos and the AoLs is up to you and the size of your group.
- Plan by:
 - Recruiting volunteers now to maintain the 1 to 4 necessary youth protection trained adult to scout ratio
 - Collecting 2019 Annual Health and Medical Record completed for each Youth and Adult attending camp. (Boy Scouts, 680-001_AB.pdf)





We Welcome All Scouts and Scouters

- **Non-Discrimination Statement**
 - Webelos Adventure Camp is available to all youth registered in the Boy Scouts of America regardless of race, creed, nationality, religious preference or gender.
- **Access Statement**
 - Webelos Adventure Camp is available to all persons with special needs and abilities. Every reasonable effort will be made to meet the needs of all campers.
 - Advanced notice of special requirements is greatly appreciated.
 - For further information or assistance, please contact the Camp Director.





Adults in Camp

- Each unit must have at least 2 Youth Protection Trained (YPT) adults in camp at all times
- An additional YPT trained adult for every four scouts.
- One adult must have BALOO training.
- Units with female scouts should have at least one female adult.

Youth (total)	Youth Protection Trained Adult
1 to 8	2
9 to 12	3
13 to 16	4
17 to 20	5
21 to 24	6
25 to 28	7
And so on...	





Camp Cost

- Registrations after the deadline will be accepted based on availability.
- Late registration begins after May 31st.

	Youth	Adult/Den Chief
In Council (MCC)	\$225	\$125
Out of Council	\$250	\$150
In Council (MCC) – After May 31st	\$250	\$150
Out of Council – After May 31st	\$270	\$170

- *Palmetto Council packs will get In Council pricing for 2023.*
- *Camperships are available. Please contact the Camp Director for details.*





Campsites and Program Areas

- In 2020, Belk Scout Camp saw many acres of trees harvested across the heart of camp.
- As a result, many campsites and program areas are not available.
- **Campsites**
 - Priority will be given to Cub World vs. Boy Scout World
 - Do you want platforms tents, or will you bring your own tents?
 - There are many fewer canvas tents available in 2023.
 - Canvas tents only in Cub World Sites 2, 3, and 4.
 - Next, we will consider the size of the groups.
 - Finally, we will look at the order of registration – First Come, First Served.
- **Program Areas**
 - IN: The lake and waterfront is available this summer for boating and fishing.
 - OUT: The Nature Lodge and nature trail are not available.
 - OUT: The perimeter trail is not open.





Vehicles in Camp

- Safety is our goal. Vehicles are the number one cause of injuries to scouts.
- As of 6:00 pm on Day 1 continuing through 9:15 am on Day 4 there will be no unauthorized vehicles allowed on camp roads.
- Only officially authorized vehicles will be permitted in camp.
- Do not leave your vehicle at the Dining Hall or any other area inside of camp. Your vehicle will be towed at your expense.
- If you need your vehicle outside of these times or there is a medical need for a vehicle, please contact the Camp Director and we will work with you for a safe solution.
- Other arrangements will be made as needed.





Uniforms at Camp

- Field Uniforms (tan or blue collared shirt) are required for:
 - Travel to/from Belk Scout Camp
 - Check-In
 - Opening/Closing Campfires
 - Scout Is Reverent/Closing Ceremonies
- All other times, Scouts and Adults will wear their Camp Uniforms (Resident Camp T-shirt or other activity shirt).
- Note: Each participant will receive one camp shirt after check-in on Day 1.
 - Additional shirts may be ordered via the registration site.





Trading Post and Meals

- Trading Post

- The camp will offer a Trading Post with a small inventory of emergency items, along with assorted snacks, refreshments as well as souvenirs. **Slushies!!!**
- The Pop-Up Trading Post will be open at opening and closing campfires.
- We recommend that each Pack establish a banking system with an adult banker to help safeguard the money the scouts bring to camp.

- Meals

- All meals will be provided starting with Day 1 dinner and going through Day 4 breakfast.
- All meals are served in the dining hall with the exception of Cast Iron Chef.
- Absolutely no food deliveries will be allowed through the gate!

- Cast Iron Chef

- Dinner Participants in this course will eat dinner at the program station.





*** New This Year ***

- Thank you volunteer scouters!
- Trading Post
 - Charging stations at some of the tables. Includes standard grounded outlets and USB ports.
 - Wi-Fi for a daily fee – \$\$\$ is TBD.
 - Sites will be restricted. No streaming.
 - Do not share the password. A Scout is Trustworthy.
 - Single serve coffee.
- Dining Hall
 - Charging station including a dozen grounded outlets.
 - To be placed on a table in the back corner of the Dining Hall.
 - Dedicated for adult use.
 - Staff will have their own charging station.





Be Prepared - Plan Ahead

- What to Bring to Camp? - Use your Scout Handbook
 - Basic Essentials – Things You Should Take with You on Every Outing
 - Overnight Gear
 - Appropriate footwear
 - Optional Items
 - Be sure to consider the activities that you have chosen
- Homesickness
 - Know your scouts
 - Talk with your parents
 - Have a plan before you arrive at camp
 - Extra bedding
 - Do not allow the scouts to call mom or dad
- If you have been to WAC before,
how have you prepared?





Questions?

Email:
WACDirector@gmail.com

