

**2009 S-8 Conclave**  
*"Here Beneath the Lights of Heaven"*  
 Camp Rockefeller, Gus Blass SR, Damascus, AR  
 April 24-26, 2009

**Participant Registration & Medical Release Form**  
**Ma Nu Lodge 133**

*Must be received (including payment and required signatures) by Last Frontier 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 **Boy Scouts of America**) \$\_\_\_\_\_

**Council Accounting Code – 6600**

*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

Check  Visa  MasterCard  Discovery  Amex

**Send completed form and payment to:**

**S-8 2009 OA Conclave Registration**  
**Last Frontier Council #480**  
**3031 NW 64<sup>th</sup> Street**  
**Oklahoma City, Oklahoma 73116-3527**

Card Number	Exp. Date
Name on Card (Print)	Verification #
Signature	