



2009 PARENT-CUB WEEKEND WILD, WILD WEST CAMP TOPENELEE

WHO? Parent-Cub Weekend is for all Cub Scouts. A fun event for Scouts to enjoy outdoor camping with Mom or Dad.

WHEN? Parent-Cub Weekend will take place the end of April. Mark your calendar for **April 25-26, 2009** and please don't forget to REGISTER!!!
Registration deadline is April 14th, 2009.

WHERE? Camp Topenelee, 377 N. Holmesville Rd, Michigan City, IN, 219-874-9455.
For additional information, call the Council (574) 289-0337

WHY? To introduce Scouts to **OUTDOOR TENT CAMPING** with the help of Mom or Dad. Fun, adventure, and new experiences await you. You must supply your own tent and personal gear. **CABINS WILL NOT BE AVAILABLE** for the weekend.

FOOD? Meals are provided, served as follows: Saturday lunch, dinner, cracker barrel, Sunday breakfast

FUN! Many activities for all to enjoy on Saturday followed by a campfire at night. Sunday breakfast will be followed by an Interdenominational Church Service.

Parent-Cub Weekend will be limited to 100 pairs of campers. A total of 200 registered participants will be accepted for the weekend (on a first come-paid basis). Please register no later than April 14th, 2009.

The cost of \$40.00 per pair will cover the cost of program supplies, event patch, and food. An additional *Scout or Adult* of the same family may register for \$15.00. Find additional information on the LaSalle Council website under Parent Cub Camp.

For questions, please contact Jody Presser, 219-326-6680, or via email at jodyindiana@comcast.net or Arne Landsverk at 574-289-0337.

CAMP RUNS ON MICHIGAN CITY, INDIANA TIME (CST)



2009 PARENT/CUB RESERVATION WILD, WILD WEST

CAMP TOPENEBEE
Michigan City, IN

CAMP DATES

April 25-26, 2008

RESERVATION DEADLINE DATE

April 14, 2009

Mail reservations to:

LaSalle Council, BSA, 1340 South Bend Ave., South Bend, IN 46617.

****Participation is limited to 200. The first 100 teams received with payment in full will have priority. Make checks payable to *LaSalle Council, BSA***

Enclosed is \$40.00 for a Parent/Cub Team:

Event Number: #480

Pack Number _____ Cub Rank (circle): Tiger Wolf Bear Webelos

District _____

Name (Cub) _____ Name (Parent) _____

Address _____ City _____ State _____

Phone (Home) _____ Email: _____

Food restrictions: _____ Person: _____

Enclosed is \$15.00 for an additional Parent and/or REGISTERED Scout:

Name (Cub) _____ Sorry, no dogs, horses, or sidekicks!
and/or _____ No "unregistered" siblings, boys must be registered Scouts.

Name (Parent) _____

You and your son will participate in the following FUN filled activities:

Shootin' Ropin' Cookin' Hikin' and more!

******CAMP RUNS ON MICHIGAN CITY, INDIANA TIME!!******

Parent/Cub Weekend Medical Forms

CUB SCOUT MEDICAL FORM:

NAME _____ BIRTHDATE _____ PACK _____
ADDRESS: _____
IN CASE OF EMERGENCY, NOTIFY: NAME _____
PHONE# _____ OTHER CONTACT _____ PHONE _____
PERSONAL INS. COMPANY _____ POLICY # _____
FAMILY DOCTOR _____ PHONE# _____

HEALTH HISTORY:

HAD OR IS SUBJECT TO PROBLEMS WITH: (PLEASE CHECK IF YES)
EYES ___ EARS ___ NOSE ___ THROAT ___ LUNGS ___ DIGESTION ___ DIABETES ___
ASTHMA ___ FAINTING SPELLS ___ CONVULSIONS ___ HEART TROUBLE ___ BEE STINGS ___
ALLERGIES TO FOOD OR MEDS? ___ DESCRIBE _____
ANY CONDITION REQUIRING REGULAR MEDICATION? _____
NAME OF MEDICATION _____
IS THIS MEDICATION WITH HIM? _____ IF NOT, WITH WHO? _____
OTHER CONDITIONS: _____
ANY RESTRICTIONS OF ACTIVITY FOR MEDICAL REASONS? _____
CHECK HERE IF NONE APPLIES: _____

THIS HEALTH HISTORY IS CORRECT TO MY KNOWLEDGE. THE PERSON HEREIN DESCRIBED HAS PERMISSION TO ENGAGE IN ALL ACTIVITIES EXCEPT AS NOTED ABOVE. IN THE EVENT OF AN EMERGENCY AND I CANNOT BE REACHED, THE ADULT LEADER IN CHARGE IS HEREBY GIVEN PERMISSION TO SEEK MEDICAL TREATMENT IF REQUIRED. THE PHYSICIAN HAS PERMISSION TO HOSPITALIZE, SECURE PROPER ANESTHESIA, OR TO COVER INJECTION OR SURGERY FOR MY SON.

SIGNED _____ DATE _____

ADULT HEALTH FORM:

NAME _____ BIRTHDATE _____
ADDRESS: _____
INCASE OF EMERGENCY, NOTIFY: NAME _____
PHONE# _____ OTHER CONTACT _____ PHONE _____
PERSONAL INS. COMPANY _____ POLICY # _____
FAMILY DOCTOR _____ PHONE# _____

HEALTH HISTORY:

HAD OR IS SUBJECT TO PROBLEMS WITH: (PLEASE CHECK IF YES)
EYES ___ EARS ___ NOSE ___ THROAT ___ LUNGS ___ DIGESTION ___ DIABETES ___
ASTHMA ___ FAINTING SPELLS ___ CONVULSIONS ___ HEART TROUBLE ___ BEESTINGS ___
ALLERGIES TO FOOD OR MEDS? ___ DESCRIBE _____
ANY CONDITION REQUIRING REGULAR MEDICATION? _____
NAME OF MEDICATION _____
IS THIS MEDICATION WITH HIM? _____ IF NOT, WITH WHO? _____
OTHER CONDITIONS: _____
ANY RESTRICTIONS OF ACTIVITY FOR MEDICAL REASONS? _____
CHECK HERE IF NONE APPLIES: _____

THIS HEALTH HISTORY IS CORRECT TO MY KNOWLEDGE. I CAN ENGAGE IN ALL ACTIVITIES EXCEPT AS NOTED ABOVE. SHOULD I BECOME UNCONSCIOUS, THE ADULT LEADER IN CHARGE HAS PERMISSION TO SEEK MEDICAL TREATMENT. THE PHYSICIAN ENGAGED HAS PERMISSION TO HOSPITALIZE, SECURE PROPER ANESTHESIA, OR TO COVER INJECTIONS OR SURGERY FOR MYSELF.

SIGNED: _____ DATE _____