

Lake Travis Fire Explorers

Contact Form



Please fill out and return to

15304 Pheasant Ln

Austin, TX 78734

Or by email to

explorers@ltfr.org

Explorer Contact

Explorer Name:	
Date of Birth:	Grade:
Gender:	

Mailing Address:	
City:	State:
ZIP Code:	

Primary Phone:
E-Mail:

Parent/Guardian Contact

(Optional if Explorer is over the age of 18)

Parent/Guardian Name:

Mailing Address:	
City:	State:
ZIP Code:	

Primary Phone:
E-Mail:

Emergency Contact

(Fill out for contacts in addition to parent/guardian)

Contact Name:
Relation:

Primary Phone:
Alternative Phone:
E-Mail:

Contact Name:
Relation:

Primary Phone:
Alternative Phone:
E-Mail:

Contact Name:
Relation:

Primary Phone:
Alternative Phone:
E-Mail:



CLUBS: For young men and women in sixth, seventh, and eighth grades who have completed the fifth grade and are at least 10 years old but have not completed the eighth grade and are not yet 15 years old.

POSTS: For young men and women who are at least 14 (and have completed the eighth grade) or 15 years of age but not yet 21 years old.

YOUTH APPLICATION

Exploring is based on a unique and dynamic relationship between youth and the organizations in their communities. Local community organizations initiate a specific Explorer post or club by matching their people and program resources to the interests of young people in the community. The result is a program of activities that helps youth pursue their special interests, grow, and develop.

Explorer posts/clubs can specialize in a variety of career skills. Exploring programs are based upon five areas of emphasis: career opportunities, life skills, citizenship, character education, and leadership experience.



Tips for completing the Application for Exploring Youth Participant:

- Print—do not use cursive.
- Use black or dark blue ink.
- Press firmly when printing.
- Print one letter only in each box.
- Use uppercase letters and stay within the blue boxes for legibility.
- Fill in circles; do not use check marks.
- Make sure you have all needed signatures on application.
- Don't alter the application—it could affect the quality of the scan.

Mailing address example:

7 0 3 F I R S T S T

Term per month	Youth/adult participant fee
1	2.00
2	4.00
3	6.00
4	8.00
5	10.00
6	12.00
7	14.00
8	16.00
9	18.00
10	20.00
11	22.00
12	24.00
13	26.00
14	28.00
15	30.00
16	32.00
17	34.00
18	36.00

Cut along dotted line.

TEMPORARY PARTICIPANT CERTIFICATE
(Good for 60 days)
This certifies that _____

is a member of _____

Post or club leader signature

Date _____

Explorer Club Exploring Real-World Career Experiences

USE BLACK OR DARK BLUE INK ONLY.

Exploring Post Explorer Club Number:

YOUTH

- Print—do not use cursive.
- Print one letter or number only in each box.
- Use uppercase letters and stay within the blue boxes for legibility.

Name: _____

Print one letter in each space—press hard, you are making a copy.

First name: K A T H L E E N Middle name: J A N E Last name: S M I T H Suffix: _____

City: A N Y T O W N State: N Y Zip code: 1 2 3 4 5

Country: U S Address: _____

Phone: (555) - 123 - 4567 Date of birth (mm/dd/yyyy): 01 / 01 / 1998 Grade: 10

School: O A K T R E E H I G H S C H O O L

Email/address (Post youth participant only): K A T H Y J S @ M Y M A I L . C O M

Ethnic background: Black/African American Native American Alaska Native Asian
 Caucasian/White Hispanic/Latino Pacific Islander Other

Gender: Male Female

Parent/guardian information: Select relationship: Parent Guardian Grandparent Other (specify) _____

Parent/guardian Name: First name (No initials or nicknames): D E B O R A H Middle name: S U E Last name: S M I T H Suffix: _____

Country: U S Mailing address: _____ City: A N Y T O W N State: N Y Zip code: 1 2 3 4 5

Home phone: (555) - 123 - 4567 Date of birth (mm/dd/yyyy): 01 / 01 / 1972 Occupation: V P O P E R A T I O N Employer: R G K I N T L Gender: M F

Business phone: (555) - 765 - 4321 Ext. _____ Previous Exploring experience: F I R E E X P L O R E R Cell phone: (555) - 253 - 6118

Parent/guardian email address: D E B O R A H . S M I T H @ _____

• Fill in radio buttons completely.

• Make sure you have all needed signatures on application.

Bill Taylor Signature of post or club leader Date: 05 / 13 / 2016

Deborah Sue Smith Signature of parent/guardian

Kathy Smith Signature of Explorer

Participation fee \$. Paid: Cash Check No. _____ Credit card

ACTIVITY CONSENT FORM AND APPROVAL BY PARENTS OR LEGAL GUARDIAN

FORMULARIO DE CONSENTIMIENTO Y APROBACIÓN DE ACTIVIDAD POR PARTE DE LOS PADRES DE FAMILIA O TUTORES

The recommended use of this form is for the consent and approval for Explorers and guests to participate in a trip, expedition, or activity. It is required for use with flying plans.

El uso recomendado de este formulario es para obtener el consentimiento y aprobación para Explorers e invitados para participar en un viaje, expedición o actividad. Es obligatorio para su uso planes de vuelo.

First name of participant Nombre del participante	Middle initial Inicial del segundo nombre	Last name Apellido
Birth date (month/day/year) _____ / _____ / _____ Fecha de nacimiento (mes/día/año)		Age during activity _____ Edad al momento de realizar la actividad

Address Domicilio		
City Ciudad	State Estado	Zip Código postal

Has approval to participate in (name of activity, orientation flight, outing trip, etc.) Tiene la aprobación para participar en (nombre de la actividad, vuelo de orientación, excursión, etc.)		From De	(Date) (fecha)		to a	(Date) (fecha)
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INFORMED CONSENT, RELEASE AGREEMENT, AND AUTHORIZATION

CONSENTIMIENTO INFORMADO, CONVENIO DE EXONERACIÓN Y AUTORIZACIÓN

I understand that participation in Exploring activities involves the risk of personal injury, including death, due to the physical, mental, and emotional challenges in the activities offered. Information about those activities may be obtained from the venue, activity coordinators, or local council. I also understand that participation in these activities is entirely voluntary and requires participants to follow instructions and abide by all applicable rules and the standards of conduct.

Entiendo que la participación en actividades Exploring implica el riesgo de lesiones personales, incluyendo la muerte, debido a los retos físicos, mentales y emocionales en las actividades que se ofrecen. Se puede obtener información sobre dichas actividades en la sede, con los coordinadores de la actividad o el concilio local. También entiendo que la participación en estas actividades es totalmente voluntaria y requiere que los participantes sigan instrucciones y acaten todas las reglas y normas de conducta pertinentes.

In case of an emergency involving my child, I understand that efforts will be made to contact me. In the event I cannot be reached, permission is hereby given to the medical provider to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child. Medical providers are authorized to disclose protected health information to the adult in charge and/or any physician or health care provider involved in providing medical care to the participant. Protected Health Information/Confidential Health Information (PHI/CHI) under the Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. §§160.103, 164.501, etc. seq., as amended from time to time, includes examination findings, test results, and treatment provided for purposes of medical evaluation of the participant, follow-up and communication with the participant's parents or guardian, and/or determination of the participant's ability to continue in the program activities.

En caso de que mi hijo se vea involucrado en una emergencia, entiendo que se realizarán esfuerzos para contactarme. En caso de que yo no pueda ser localizado, por este medio otorgo permiso al proveedor de servicios médicos para garantizar el tratamiento adecuado, incluyendo hospitalización, anestesia, cirugía o inyecciones de medicamentos para mi hijo. Los proveedores de servicios médicos están autorizados a revelar información médica protegida al adulto a cargo, médico o proveedor de servicios médicos involucrado en la prestación de atención médica para el participante. La Información de salud protegida/Información médica confidencial (PHI/CHI, por sus siglas en inglés) bajo los Estándares de privacidad de información médica individualmente identificable, 45 C.F.R. §§ 160.103, 164.501, etc., y siguientes, como se enmiendan de vez en cuando, incluyen resultados de reconocimientos médicos, resultados de pruebas y el tratamiento proporcionado para fines de evaluación médica del participante, seguimiento y comunicación con los padres o tutor legal del participante, o determinación de la capacidad del participante para continuar en las actividades del programa.

With appreciation of the dangers and risks associated with programs and activities including preparations for and transportation to and from the activity, on my own behalf and/or on behalf of my child, I hereby fully and completely release and waive any and all claims for personal injury, death, or loss that may arise against the Boy Scouts of America, Learning for Life, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with any program or activity.

Con reconocimiento de los peligros y riesgos asociados con los programas y actividades incluyendo preparativos y transportación hacia y desde la actividad, en mi propio nombre o en nombre de mi hijo, por este conducto eximo total y completamente, y renuncio a cualquiera y toda reclamación por lesiones personales, muerte o pérdidas que puedan surgir, a la organización Boy Scouts of America, Learning for Life, el concilio local, los coordinadores de la actividad y todos los empleados, voluntarios, grupos involucrados, u otras organizaciones asociadas con cualquier programa o actividad.

NOTE: The Boy Scouts of America, Learning for Life and local councils cannot continually monitor compliance of program participants or any limitations imposed upon them by parents or medical providers. List any restrictions imposed on a child participant in connection with programs or activities below and counsel your child to comply with those restrictions.

NOTA: La organización Boy Scouts of America, Learning for Life y los concilios locales no pueden vigilar continuamente el cumplimiento de los participantes del programa o cualquier limitación impuesta sobre ellos por los padres o proveedores de servicios médicos. Enumerar más abajo las restricciones impuestas a un niño participante en relación con los programas o actividades.

List participant restrictions, if any: _____
 None

Restricciones del participante, si existen: _____
 Ninguna

Participant's signature Firma del participante	Date Fecha
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Parent/guardian printed name Nombre con letra de molde del padre de familia/tutor	Parent/guardian signature Firma del padre de familia/tutor	Date Fecha
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Area code and telephone number (best contact and emergency contact) Código de área y número telefónico (primer contacto y contacto de emergencia)	Email (for use in sharing more details about the trip or activity) Correo electrónico (para informar más detalles sobre el viaje o actividad)
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Contact the adult leader with any questions:
Póngase en contacto con el líder adulto si es que tiene preguntas:

Name Nombre	Phone Teléfono	Email Correo electrónico
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Part A: Informed Consent, Release Agreement, and Authorization

Full name: _____
 Date of birth: _____

High-adventure base participants:
 Expedition/crew No.: _____
 or staff position: _____

Informed Consent, Release Agreement, and Authorization

I understand that participation in Exploring activities involves the risk of personal injury, including death, due to the physical, mental, and emotional challenges in the activities offered. Information about those activities may be obtained from the venue, activity coordinators, or your local council. I also understand that participation in these activities is entirely voluntary and requires participants to follow instructions and abide by all applicable rules and the standards of conduct.

In case of an emergency involving me or my child, I understand that efforts will be made to contact the individual listed as the emergency contact person by the medical provider and/or adult leader. In the event that this person cannot be reached, permission is hereby given to the medical provider selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for me or my child. Medical providers are authorized to disclose protected health information to the adult in charge, camp medical staff, camp management, and/or any physician or health-care provider involved in providing medical care to the participant. Protected Health Information/Confidential Health Information (PHI/CHI) under the Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. §§160.103, 164.501, etc. seq., as amended from time to time, includes examination findings, test results, and treatment provided for purposes of medical evaluation of the participant, follow-up and communication with the participant's parents or guardian, and/or determination of the participant's ability to continue in the program activities.

(If applicable) I have carefully considered the risk involved and hereby give my informed consent for my child to participate in all activities offered in the program. I further authorize the sharing of the information on this form with any Exploring volunteers or professionals who need to know of medical conditions that may require special consideration in conducting Exploring activities.


With appreciation of the dangers and risks associated with Exploring programs and activities, on my own behalf and/or on behalf of my child, I hereby fully and completely release and waive any and all claims for personal injury, death, or loss that may arise against Learning for Life, Exploring, the Boy Scouts of America, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with any program or activity.

I also hereby assign and grant to the local council, Learning for Life, Exploring, and the Boy Scouts of America, as well as their authorized representatives, the right and permission to use and publish the photographs/film/videotapes/electronic representations and/or sound recordings made of me or my child at all Exploring activities, and I hereby release Learning for Life, Exploring, the Boy Scouts of America, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with the activity from any and all liability from such use and publication. I further authorize the reproduction, sale, copyright, exhibit, broadcast, electronic storage, and/ or distribution of said photographs/film/videotapes/electronic representations and/or sound recordings without limitation at the discretion of Learning for Life, Exploring, and the Boy Scouts of America, and I specifically waive any right to any compensation I may have for any of the foregoing.

Every person who furnishes any BB device to any minor, without the express or implied permission of the parent or legal guardian of the minor, is guilty of a misdemeanor. (California Penal Code Section 19915[a]) My signature below on this form indicates my 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.

 **NOTE: Due to the nature of programs and activities, Learning for Life, Exploring, 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

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 Philmont Scout Ranch, Philmont 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: _____

Part B1: General Information/Health History

Full name: _____

Date of birth: _____

High-adventure base participants:

Expedition/crew No.: _____

or staff position: _____

Age: _____ Gender: _____ Height (inches): _____ Weight (lbs.): _____

Address: _____

City: _____ State: _____ ZIP code: _____ Phone: _____

Unit leader: _____ Unit leader's mobile #: _____

Council Name/No.: _____ Unit No.: _____

Health/Accident Insurance Company: _____ Policy No.: _____



Please attach a photocopy of both sides of the insurance card. If you do not have medical insurance, enter "none" above.

In case of emergency, notify the person below:

Name: _____ Relationship: _____

Address: _____ Home phone: _____ Other phone: _____

Alternate contact name: _____ Alternate's phone: _____

Health History

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

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

Part B2: General Information/Health History

Full name: _____

Date of birth: _____

High-adventure base participants:

Expedition/crew No.: _____

or staff position: _____

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	Yes	No	Allergies or Reactions	Explain
		Medication				Plants	
		Food				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 Non-prescription medication administration is authorized with these exceptions: _____

Administration of the above medications is approved for youth by:

_____/_____
 Parent/guardian signature MD/DO, NP, or PA signature (if your state requires signature)



Bring enough medications in sufficient quantities and in the original containers. Make sure that they are NOT expired, including inhalers and EpiPens. You SHOULD NOT STOP taking any maintenance medication unless 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)
			Tetanus	
			Pertussis	
			Diphtheria	
			Measles/mumps/rubella	
			Polio	
			Chicken Pox	
			Hepatitis A	
			Hepatitis B	
			Meningitis	
			Influenza	
			Other (i.e., Hib)	
			Exemption to immunizations (form required)	

Please list any additional information about your medical history:

DO NOT WRITE IN THIS BOX.

Review for camp or special activity.

Reviewed by: _____

Date: _____

Further approval required: Yes No

Reason: _____

Approved by: _____

Date: _____