SPECIAL MEDICAL NEEDS FORM

Participant Name_____ ☐ Pack ☐ Troop ☐ Crew #_____

Parent Name_____

Phone_____ Email_____

Camp: ☐ Scouts BSA Summer Camp ☐ Cub Scout Day Camp ☐ Cub Scout Overnight Camp

☐ Webelos & Arrow of Light Overnight Camp ☐ Other_____

Camp/Event Dates_____

Please describe the participant's medical needs in detail:_____

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Please turn this form in at the 10-day-out meeting!

Questions? Please contact:
CHTBleadership@tecumsehcouncil.org

Scouting America
Tecumseh Council