Ta Tanka Lodge Order of the Arrow

2010

MEMBER LODGE REGISTRATION FORM

MEMBER INFORMATION

Name: _____ _____
E-mail Address:

Address: _____ Mobil Phone: (_____) _____ - _____

City: _____ ZIP: _____ Daytime Phone: (_____) _____ - _____

Date of Birth: _____ Nighttime Phone: (_____) _____ - _____

Unit registered with: Pack #_____ Troop #_____ Team #_____ Council / District _____

Has any member of your family ever been a member of the Order of the Arrow? Yes / No

Are they registered with Ta Tanka Lodge #488 Yes / No

Please notify your Chapter Chief of any changes to your mailing and e-mail address

REGISTRATION INFORMATION: First year's Annual Dues of $15.00 per member are paid with cost of Induction.

Date Registered: _____ (Check one) Chapter you're registering with:

___ Hunkpapa (Lucky Baldwin / El Camino Real) 2371-022

___ Kiowa (Golden Eagle) 2371-024

___ Oglala Lakota (Rose Bowl / Mission Amigos) 2371-020

___ Teton Dakota (Trails of the Valley / Valle Del Sol) 2371-023

ARCHERY, BBS .22 RIFLES CONSENT

I give consent for _____, who is my son or ward, to use the following equipment:

☐ Archery Equipment ☐ B.B. Guns ☐ .22 Rifles ☐ Shotgun

at Camp Cherry Valley, Holcomb Valley, or Trask Scout Reservation.

_____ _____

Date Signature of Parent or Guardian

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NEW MEMBER REGISTRATION FORM

MEDICAL INFORMATION *For ALL Adult and Youth members* (Youth are under 18 years of age on the date that this form is submitted). During the year, if the medical provider / insurance information may change, it is important that you contact the Lodge with the current information.

CONTINUING CONSENT TO TREAT MINOR CHILD

We, the undersigned, parents or guardians of _____, a minor, do hereby consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital service that may be rendered to said minor under the general or specific instructions of a physician licensed to practice in the United States, whether such diagnosis or treatment is rendered at the office of said physician or at a hospital licensed by the medical authority of any State of the United States.

It is understood that consent is given in advance of any specific diagnosis, treatment or hospital care being required, but is given in order that said physician may have the opportunity to exercise best judgment as to the action which may be necessary or required to protect the life and health of said minor child.

This consent shall remain effective until revoked in writing by the parents or guardian of said minor.

_____ _____

Date Signature of Parent or Guardian

Day Time Phone: (____) _____-_____ Night Time Phone: (____) _____-_____

MEDICAL INSURANCE INFORMATION

Health Insurance Provider: _____

Address: _____

_____

Telephone Number: (____) _____-_____ Ext. (if necessary)_____

Health Insurance Policy Identification or other Identification Information that will provide immediate treatment

_____

_____

MINOR'S PHYSICIAN

Name: _____ Telephone Number: (____) _____-_____

Street Address: _____

City: _____ State: _____ZIP: _____-_____

MEDICATION AND ALLERGIES

Prescription Medicine: _____

Allergies: _____