



## Stamp Collecting Merit Badge Workshop

### AMERICAN PHILATELIC SOCIETY STAMPSHOW 2009

David L. Lawrence Convention Center  
1000 Fort Duquesne Boulevard  
Pittsburgh, PA

Friday or Saturday, August 7 or 8, 10 a.m. –4 p.m.  
Reservation Deadline: July 20, 2009  
Register early as workshop space limited

Please reserve a space at the Stamp Collecting Merit Badge Workshop on August 7 or August 8, 2009 at the David L. Lawrence Convention Center, Pittsburgh, PA. The registration fee for each Scout is \$15.00. No refunds will be given after July 20, 2009, for Scouts who do not attend. The fee includes materials and beverages, but does not include lunch. Each participant should bring a bagged lunch.

Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, ZIP \_\_\_\_\_

Telephone \_\_\_\_\_ E-mail \_\_\_\_\_

Troop Number \_\_\_\_\_ Rank \_\_\_\_\_

I would like to attend the workshop on: (circle one) August 7, 2009 August 8, 2009

Areas of Collecting Interest: (This information will be used to prepare stamp packets.)

- Worldwide                       Topical: Animals                       Topical: Plants  
 Topical: Flags                       Topical: Transportation                       Country, \_\_\_\_\_

Before you mail the form, be sure to complete the following:

- Fill out all information on side 1: Name, Address, Troop, Rank
- Fill out all information on side 2: Class 1 Personal Health History
- Enclose registration fee of \$15. Make check payable to APS.

For more information, please contact:

Janet Houser  
American Philatelic Society Youth Program Coordinator  
814-933-3820 oysca@stamps.org  
Weekdays, 8:00 am–4:30 pm

Mail to:  
American Philatelic Society  
Scout Merit Badge Program  
100 Match Factory Place





# PERSONAL HEALTH AND MEDICAL RECORD

## CLASS 1 AND CLASS 2

Height \_\_\_\_\_ Weight \_\_\_\_\_ Eye color \_\_\_\_\_ Hair color \_\_\_\_\_

To be filled out by parent, guardian, or adult participant. Please print in ink.

### IDENTIFICATION

Name \_\_\_\_\_ Date of birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Name of parent or guardian \_\_\_\_\_ Telephone \_\_\_\_\_

Home address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

If person named above is not available in the event of an emergency, notify

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Telephone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Telephone \_\_\_\_\_

Name of personal physician \_\_\_\_\_ Telephone \_\_\_\_\_

Personal health/accident insurance carrier \_\_\_\_\_ Policy No. \_\_\_\_\_

Check all items that apply, **past or present**, to your health history. Explain any "Yes" answers.

**ALLERGIES:** Food, medicines, insects, plants Yes No Explain: \_\_\_\_\_

**GENERAL INFORMATION:** Yes No Yes No Yes No

ADHD (Attention-Deficit   Convulsions/seizures   Hemophilia

Asthma   Diabetes   High blood pressure

Cancer/leukemia   Heart trouble   Kidney disease

Explain: \_\_\_\_\_

Please list ALL medications taken in the 30 days **prior** to arrival at the Scouting activity where this form is to be used: \_\_\_\_\_

List any **medications to be taken at camp**, including drug, dosage, route (oral, injection, etc.), and frequency: \_\_\_\_\_

List any physical or behavioral conditions that may affect or limit full participation in the Stamp Collecting Merit Badge program: \_\_\_\_\_

List equipment needed such as wheelchair, braces, glasses, contact lenses, etc.: \_\_\_\_\_

**Immunizations:** (Give date of last inoculation.)

Tetanus toxoid \_\_\_\_\_ Measles \_\_\_\_\_ Polio \_\_\_\_\_

OR DPT \_\_\_\_\_ OR MMR \_\_\_\_\_ Hepatitis A \_\_\_\_\_  
Varicella \_\_\_\_\_ OR Chicken pox \_\_\_\_\_ Hepatitis B \_\_\_\_\_

I give permission for full participation in BSA programs, subject to limitations noted herein. **In case of emergency**, I understand every effort will be made to contact me. In the event I cannot be reached, I hereby give my permission to the licensed health-care practitioner selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child

Date \_\_\_\_\_ Signature of parent/guardian or adult \_\_\_\_\_

**Some hospitals require the parent/guardian signature to be notarized. Check with your BSA local council.**