ADIRONDACK HIGH ADVENTURE TREK PROGRAM

PLEASE FILL OUT THE ATTACHED ROSTER AND RETURN TO THE ROCHESTER OFFICE ON JUNE 1ST WITH FINAL PAYMENT.

ALL TREK FEES WILL BE INCREASED $10.00 PER PERSON ON ALL FINAL PAYMENTS RECEIVED AFTER JUNE 1ST.

PLEASE MAKE CHECKS PAYABLE TO THE “BOY SCOUTS OF AMERICA”

RETURN ROSTER AND PAYMENT TO:

MASSAWEPIE TREK PROGRAM
OTETIANA COUNCIL, BSA
474 EAST AVENUE
ROCHESTER, NY 14607

MASSAWEPIE SCOUT CAMPS BOY SCOUTS OF AMERICA

ADIRONDACK ADVENTURE TREK ADULT ROSTER

(PLEASE PRINT)

TREK WEEK DATE ______________ TREK PLAN ____________________ UNIT # __________

TREK LEADER NAME _____________________________________E-Mail _________________________

ADDRESS ____

CITY __________________________________ STATE ___________________________ ZIP ____________

PHONE-HOME ( )_____________________________ BUSINESS ( )____________________________

*NAME/EMERGENCY NUMBER (H)_________________ (B)_________________(C)______________

ADDITIONAL ADULTS

TREK WEEK DATE ______________ TREK PLAN ____________________ UNIT # __________

TREK LEADER NAME _____________________________________E-Mail _________________________

ADDRESS ____

CITY __________________________________ STATE ___________________________ ZIP ____________

PHONE-HOME ( )_____________________________ BUSINESS ( )____________________________

*NAME/EMERGENCY NUMBER (H)_________________ (B)_________________(C)______________

TREK WEEK DATE ______________ TREK PLAN ____________________ UNIT # __________

TREK LEADER NAME _____________________________________E-Mail _________________________

ADDRESS ____

CITY __________________________________ STATE ___________________________ ZIP ____________

PHONE-HOME ( )_____________________________ BUSINESS ( )____________________________

*NAME/EMERGENCY NUMBER (H)_________________ (B)_________________(C)______________

*** LIST NAME AND TELEPHONE NUMBER(S) OF MOST KNOWLEDGEABLE CONTACT PERSON WHO KNOWS YOUR PLANS**

MASSAWEPIE SCOUT CAMPS **BOY SCOUTS OF AMERICA**

YOUTH TREK PARTICIPANTS

(PLEASE PRINT)

1. NAME ______________________________

ADDRESS ______________________________

CITY ____________________ STATE ____________ ZIP ________

NAME OF PARENTS OR GUARDIAN ______________________________

PHONE – H:( ) ____________ B:( ) ____________ C:( ) ____________

PERSON TO CONTACT IN EMERGENCY IF PARENTS ARE NOT HOME:

NAME ____________________ ADDRESS ____________________

PHONE – H:( ) ____________ B:( ) ____________ C:( ) ____________

HEALTH CONCERNS & RESTRICTIONS (I.e., bee bites, asthma, insulin)

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2. NAME ______________________________

ADDRESS ______________________________

CITY ____________________ STATE ____________ ZIP ________

NAME OF PARENTS OR GUARDIAN ______________________________

PHONE – H:( ) ____________ B:( ) ____________ C:( ) ____________

PERSON TO CONTACT IN EMERGENCY IF PARENTS ARE NOT HOME:

NAME ____________________ ADDRESS ____________________

PHONE – H:( ) ____________ B:( ) ____________ C:( ) ____________

HEALTH CONCERNS & RESTRICTIONS (I.e., bee bites, asthma, insulin)

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3. NAME ____

ADDRESS ____

CITY ______________________ STATE ____________ ZIP __________

NAME OF PARENTS OR GUARDIAN ______________________________

PHONE – H:(   ) ____________ B:(   ) ____________ C:(   ) ____________

PERSON TO CONTACT IN EMERGENCY IF PARENTS ARE NOT HOME:

NAME ________________ ADDRESS ____________________

PHONE – H:(   ) ____________ B:(   ) ____________ C:(   ) ____________

HEALTH CONCERNS & RESTRICTIONS (I.e., bee bites, asthma, insulin)

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4. NAME ____

ADDRESS ____

CITY ______________________ STATE ____________ ZIP __________

NAME OF PARENTS OR GUARDIAN ______________________________

PHONE – H:(   ) ____________ B:(   ) ____________ C:(   ) ____________

PERSON TO CONTACT IN EMERGENCY IF PARENTS ARE NOT HOME:

NAME ________________ ADDRESS ____________________

PHONE – H:(   ) ____________ B:(   ) ____________ C:(   ) ____________

HEALTH CONCERNS & RESTRICTIONS (I.e., bee bites, asthma, insulin)

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5. NAME ____

ADDRESS ____

CITY ______________________________ STATE _____________ ZIP __________

NAME OF PARENTS OR GUARDIAN ____

PHONE – H:( ) _______________ B:( ) _______________ C:( ) _______________

PERSON TO CONTACT IN EMERGENCY IF PARENTS ARE NOT HOME:

NAME _______________________ ADDRESS _____________________________

PHONE – H:( ) _______________ B:( ) _______________ C:( ) _______________

HEALTH CONCERNS & RESTRICTIONS (I.e., bee bites, asthma, insulin)

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6. NAME ____

ADDRESS ____

CITY ______________________________ STATE _____________ ZIP __________

NAME OF PARENTS OR GUARDIAN ____

PHONE – H:( ) _______________ B:( ) _______________ C:( ) _______________

PERSON TO CONTACT IN EMERGENCY IF PARENTS ARE NOT HOME:

NAME _______________________ ADDRESS _____________________________

PHONE – H:( ) _______________ B:( ) _______________ C:( ) _______________

HEALTH CONCERNS & RESTRICTIONS (I.e., bee bites, asthma, insulin)

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7. NAME ______________________________

ADDRESS ______________________________

CITY ______________________ STATE ____________ ZIP __________

NAME OF PARENTS OR GUARDIAN ______________________________

PHONE – H:( ) ____________ B:( ) ____________ C:( ) ____________

PERSON TO CONTACT IN EMERGENCY IF PARENTS ARE NOT HOME:

NAME ________________ ADDRESS ________________

PHONE – H:( ) ____________ B:( ) ____________ C:( ) ____________

HEALTH CONCERNS & RESTRICTIONS (I.e., bee bites, asthma, insulin)

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8. NAME ______________________________

ADDRESS ______________________________

CITY ______________________ STATE ____________ ZIP __________

NAME OF PARENTS OR GUARDIAN ______________________________

PHONE – H:( ) ____________ B:( ) ____________ C:( ) ____________

PERSON TO CONTACT IN EMERGENCY IF PARENTS ARE NOT HOME:

NAME ________________ ADDRESS ________________

PHONE – H:( ) ____________ B:( ) ____________ C:( ) ____________

HEALTH CONCERNS & RESTRICTIONS (I.e., bee bites, asthma, insulin)

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9. NAME ____

ADDRESS ____

CITY ______________________ STATE ____________ ZIP __________

NAME OF PARENTS OR GUARDIAN ______________________________

PHONE – H:( ) ____________ B:( ) ____________ C:( ) ____________

PERSON TO CONTACT IN EMERGENCY IF PARENTS ARE NOT HOME:

NAME ____________________ ADDRESS ________________________

PHONE – H:( ) ____________ B:( ) ____________ C:( ) ____________

HEALTH CONCERNS & RESTRICTIONS (I.e., bee bites, asthma, insulin)

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10. NAME ____

ADDRESS ____

CITY ______________________ STATE ____________ ZIP __________

NAME OF PARENTS OR GUARDIAN ______________________________

PHONE – H:( ) ____________ B:( ) ____________ C:( ) ____________

PERSON TO CONTACT IN EMERGENCY IF PARENTS ARE NOT HOME:

NAME ____________________ ADDRESS ________________________

PHONE – H:( ) ____________ B:( ) ____________ C:( ) ____________

HEALTH CONCERNS & RESTRICTIONS (I.e., bee bites, asthma, insulin)

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