



Master Guides Club Registration Form

Desire (check as appropriate):

Apply for membership or Renew my membership

Transfer my membership from _____

Personal Information

Name _____ Age _____ Date of birth _____

Address _____

City _____ State _____ Zip Code _____

Email: _____ Cell phone () _____

Name of the church you attend _____ ¿Baptized? Y N

Mark all the levels you have completed: L. Lambs E. Beaver Busy Bee Sunbeam

Builder Helping Hands

Friend Companion Explorer Ranger Voyagers Guides

COMMITMENT OF THE APPLICANT: I agree to abide by the rules of the Club and the Vote and Law of the Senior Guide, as well as to attend Club meetings, camps and other outings and activities of the Club. I agree to abide by the club rules and principles of the Seventh-day Adventist Church.

Applicant's Signature

FAMILY HISTORY

Name of parent or representative: _____

Email: _____ Cell phone () _____

Member of the Seventh-day Adventist Church? Y N

If the answer is yes, where do you have your membership? _____

MEDICAL CONSENT FORM

To be read and completed by the parent or guardian and if your state/province requires notarization.

Legal name of the Master Guide _____
Date of birth _____ Circle: Male/Female
Address _____
City _____ State _____ Zip Code _____
Name of Parent or Guardian: _____
Cell phone (____) _____

Family doctor's name _____ Phone (____) _____
Health Insurance Provider _____
Health Insurance Policy Number _____
Name of parent or Gardian _____
Address _____
City _____ State _____ Zip Code _____
Home phone (____) _____ Cell phone (____) _____

MEDICAL HISTORY

Weight _____ Height _____ Last tetanus vaccine _____
Food allergy: _____ Blood Type _____
Drug allergy _____
Medications you are currently taking : _____

Medical history (recent operations, diabetes, chronic illnesses)

Contact person in case of accident or illness if parents or guardians are not available.

Name _____

Phone number(_____) _____ Relationship with the minor _____

I _____ (parent/guardian) I give the following consent of

Emergency medical treatment for the minor mentioned above.

Valid from _____ until _____

Emergency operation First aid (check each as appropriate)



Name: _____

The following information will be used for all club activities for the 2023-2024 Master Guide year.

Please note on the event permission form if there are any changes from this information.

All events will be sponsored by the Arkansas-Louisiana Conference and/or the _____ SDA Church, _____, _____. I do hereby state that said child is physically and medically able to participate in the club activities. I do hereby release and discharge the SDA Church and its authorized representatives and staff from all liability of any kind and character upon any claim, demand, or cause of action which might be asserted on behalf of said minor and/or myself against the _____ SDA Church, representatives, or staff. Furthermore, in the event of an accident, if said staff or representatives are unable to contact the undersigned, I hereby grant permission to said staff or representative to administer first aid, and/or to take the applicant to a medical facility for treatment.

Signed: _____ Date: _____

Printed Name: _____ Cell #: _____

Relationship to applicant: _____

Please check any OTC (over the counter) meds that the staff is allowed to give the Master Guides.

- Ibuprofen (headache, muscle ache or pain)
- Acetaminophen (as needed headache or pain)
- Robitussin (cough)
- Loperamide Hydrochloride 2 mg (diarrhea)
- Visine or clear eye drops (itching eyes)
- Mylanta, Maalox or Tums (upset stomach)
- Antibiotic ointment (wound care)
- Cortisone cream (insect bites, poison ivy)
- Benadryl caplets (insect bite, allergy)
- Caladryl cream (itching)
- Cough Drops (cough)

Special Instructions

Medications currently taken by the applicant and any allergic reactions for this applicant must be listed below along with the applicant's doctor's name and phone number.

If Master Guide has own medications, they must be kept and administered by staff.

Medications _____

Drug Allergies _____ Blood Type _____

Food Allergies _____

Doctor _____ Phone _____

Dentist _____ Phone _____