

## 2001 Cahuilla Lodge Fall **Fellowship**

## What Do You Do?

Sports! Patch Trading!

Give Service! Chapter Competitions! Meet the new Vigil Honor Members! Meet New People!

Fellowship! Lodge Officer **Elections!** Fun Show! Lots Of Spirit!

Inspiration!

Have FUN!

September 7 – 9, 2001 at beautiful Camp Emerson

**\$17.00** (if paid by September 1, 2001) \$22.00 (if paid after September 1, 2001) \$10.00 (if you are sealing your ties of **Brotherhood**)

(NOTE: Those under 18 MUST have a consent to treat form filled out and signed to attend!)

YES! Sign Me Up For The Best Cahuilla Lodge Event Of The Year! Please mail to: 2001 OA Fall Fellowship CIEC – BSA 1230 Indiana Court Redlands, CA 92374 ")

Office Use Only: Receipt #: Date Received:

(	(NOTE:	<b>Checks should</b>	be made pay	yable to "Bo	y Scouts of	America

	Name	Chapter	Age	Check All That Apply		Total Fees (\$):
1			Youth Adult	Early Bird Registration F Late Registration Fee (\$2 Brotherhood (\$10.00)		
2			Youth Adult	Early Bird Registration F Late Registration Fee (\$ Brotherhood (\$10.00)		
3			Youth Adult	Early Bird Registration F Late Registration Fee (\$2 Brotherhood (\$10.00)		
4			Youth Adult	Early Bird Registration F Late Registration Fee (\$ Brotherhood (\$10.00)		
5 S Youth		Youth Adult	<ul> <li>Early Bird Registration Fee (\$17.00)</li> <li>Late Registration Fee (\$22.00)</li> <li>Brotherhood (\$10.00)</li> </ul>			
					Grand Total (\$):	

## MUST BE COMPLETED IF UNDER 18 YEARS OF AGE!!!

Name of Minor

Date of Birth

I/We give permission for my/our son to attend the regularly scheduled Order of the Arrow event to be held on its corresponding registered date. I also authorize the California Inland Empire Council, Boy Scouts of America, or such substitute, as designated, as agent for the undersigned, to consent to an X-ray examination, anesthetic, medical, dental or surgical diagnosis or treatment and hospital care for the above minor which is deemed advisable by, and to be rendered under, the general or special supervision if any physician or surgeon, licensed under the Provision of Medicine Act, or any dentist licensed under the Dental Practice Act, where such diagnosis or treatment is rendered at the office of said physician or dentist at a hospital, scout camp, or elsewhere.

Parent/Guardian (print)	Signature					
Address	City		Zip			
Home Phone	Work Phone					
Are You Covered by Medical Insurance?	Yes	Company Name and Policy Number				
Alternate Person To Contact	Relationship		Phone			
DON'T FORGET TO BRING THIS FORM WITH YOU TO THE EVENT						