St. George Pathfinders, Inc.
Western American Region
Division "Kiev"
http://www.sgpsf.org
Facebook: Druzhina Kiev – St. George Pathfinders

ANNUAL DUES 2018 / ГОДОВЫЕ ЧЛЕНСКИЕ ВЗНОСЫ 2018

Годовые членские взносы / Dues this year are:

$80 каждый член / per individual member

$60 Скауты пенционного воазраста / Special Pricing per Individual Retiree

Camp attendance requires 30 hours of volunteer time per family. These hours can be accomplished by helping out at our fundraisers, working on special projects, and helping out on work weekends or camp.

Please make checks payable to "St. George Pathfinders" and send to address listed directly below along with your completed release forms **by March 15.**

St. George Pathfinders
c/o Irene Motoviloff
2508 Poppy Drive
Burlingame, CA 94010

To be fully registered you must return all three items:

1. Signed Medical Consent Form
2. Photo/Insurance Information Form
3. Dues Payment (late fees may apply to renewing members who do not pay by the deadline)

Note:

A child will not be able to participate in Druzhina "Kiev" events unless Medical Release and Consent forms are on file.

Please notify us if any of your contact information changes during the year.

St. George Pathfinders, Inc.
Western American Region
Division "Kiev" / Division "Nizhni Novgorod"

OFFICE USE ONLY:
Check #:_____
Date:_____
Amount:_____

ADULT CONSENT FOR MEDICAL AND SURGICAL CARE FORM

I _____ (your name) hereby give my consent to receive medical or surgical treatment and to be hospitalized if necessary in case of injury or possible sickness while participating in the 2018/2019 program and/or traveling with the St. George Pathfinders.

It is agreed that in the event of sickness, injury or accident I will assume full financial responsibility for the payment of medical and/or other costs.

It is further recognized and agreed that St. George Pathfinders, their officers and individuals placed in charge, will not be liable in any way for accidents, injury or other mishaps whether the result of negligence or other cause.

It is understood that in case of emergency every effort will be made to contact the person listed below.

IN CASE OF EMERGENCY PLEASE CONTACT:

Name: _____ Relationship: _____

Phone: Res: _____ Cell: _____

List below the medical insurance in effect for the individual signing this form:

Name of Insurance Company: _____

Policy Number: _____ Date of Birth_____

I am known to be allergic to the following foods and medications. Additionally, special attention should be paid to the following medical problem: (e.g. other allergies, fainting, diabetes, heart disease, epilepsy, etc.)

_____

SIGNATURE SIGNIFIES CONSENT/AUTHORIZATION THROUGH 3/31/2019 UNLESS OTHERWISE SPECIFIED.

Signature (Legal Name) _____ Date _____

Address: _____ City/State/Zip:_____

Email Address: _____

Phone: Res: _____ Cell: _____