

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 \$20.00 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
SENECA WATERWAYS COUNCIL, BSA
474 EAST AVENUE
ROCHESTER, NY 14607**

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**

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)

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)

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)

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)

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)

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)

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)

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)

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)

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)

