

## **BOY SCOUTS OF THE PHILIPPINES**

National Office  
Manila

16 July 2012

### **NATIONAL OFFICE MEMORANDUM**

**No. 32**

**s. 2012**

**TO : Regional Scout Directors, Council Scout Executives and Officers-In-Charge**

**SUBJECT : EMERGENCY SERVICE INSTRUCTORS TRAINING COURSE**

1. The Boy Scouts of the Philippines has scheduled the conduct of an Emergency Service Instructors Training Course for Luzon Regions on August 27-31, 2012 at Makiling, Los Baños, Laguna, in support of the approved 56<sup>th</sup> ANCM Resolution no. 3 – Requiring all Local Councils to organize Emergency Service Corps. (N.O. Memo no. 27, dated 31 May 2012).
2. The training will prepare the participants to further enhance Local Councils capability in training more adult leaders responsible in providing Scouts, particularly the Senior and Rover Scouts necessary skills needed to cope with and/or respond to an emergency situation and be able to serve as the Emergency Service Corps of their community and the like in the course and call of their duty.
3. Regional Scout Directors are requested to ensure that each Local council will send at least one(1) participant, as they will compose the Regional Team responsible to train Council Training Team to conduct the Course at Council level.
4. **Qualifications for Admission:**
  - a) At least two-bead holder with NTC/CALT/CML and currently registered with the BSP.
  - b) Has the ability to re-echo training sessions, physically and mentally capable to undergo strenuous activities.
  - c) Can perform the following:
    - 1 Km Run in 6mins.
    - 3M Rope Climb (hand over hand)
    - Push-ups 15 times
    - Pull-ups 10 times
    - Swimming (50meters)
5. **Application to Attend:** Applications with the Medical Examination Form properly accomplished and endorsed by the Local Council/Region together with a reservation fee of **TWO THOUSAND PESOS (P 2,000.00)** which is non – refundable but transferable should reach National Office not later than **August 08, 2012** to give us enough time to process applications for confirmation of attendance.

6. **Registration Fee:** Each participant will be charged **FOUR THOUSAND FIVE HUNDRED PESOS (P 4,500.00)** to defray cost of meals (dinner before the start of the course, until lunch of the closing date, accommodation, training materials/supplies, handouts, and other administrative expenses).

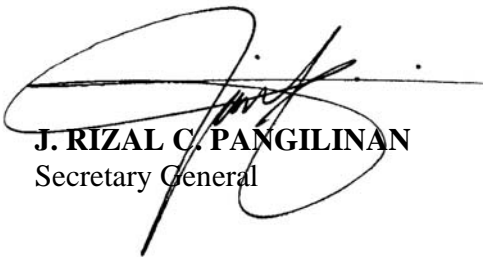
In case the participant endorsed by the Council/Region fails to attend, the usual arrangement of automatically deducting the reservation fee from NAFCO shall be made.

7. **Reporting Date:** All participants must be at the course venue for orientation and organization not later than **4:00 p.m. of the day before the course starts.**

8. **Items Needed:** Participants must bring along the required items listed hereunder:

- \_\_\_ current BSP membership card
- \_\_\_ one piece 1 x 1 current ID picture
- \_\_\_ two sets, Type-A Uniform (short with socks, garter tabs & 1 long pants)
- \_\_\_ tent, sleeping gears, personal eating , cooking gears
- \_\_\_ personal gears (maong pants, handkerchief, underwear, sportswear, casual attire, swimming trunks/suit, t-shirts, jacket, extra clothing for work, etc.)
- \_\_\_ rubber shoes, slippers/sandals
- \_\_\_ raincoat/gear/plastic sheets
- \_\_\_ first aid kit/medicines, flashlight, sewing kit, toiletries
- \_\_\_ utility knife, compass, whistle
- \_\_\_ 3 meter 3/8 or 10 mm rescue rope
- \_\_\_ reference materials/books

9. For information, guidance and wide dissemination.



**J. RIZAL C. PANGILINAN**  
Secretary General

Encl: Application to Attend  
Medical Examination Form

**BOY SCOUTS OF THE PHILIPPINES**  
**National Office**  
**Manila**

**APPLICATION TO ATTEND**  
**EMERGENCY SERVICE INSTRUCTORS TRAINING COURSE**

Venue	Region
Date	Council

Name: \_\_\_\_\_ Nickname: \_\_\_\_\_  
(Surname) (Given Name) (Middle Name)

Mailing Address: \_\_\_\_\_

CP No. \_\_\_\_\_ Email \_\_\_\_\_ Tel. No. \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

Civil Status: \_\_\_\_\_ Religion: \_\_\_\_\_ Occupation: \_\_\_\_\_

Business Address: \_\_\_\_\_

Tel. No. (Landline) \_\_\_\_\_ Fax No. \_\_\_\_\_

Scouting Position: \_\_\_\_\_ Unit & No. \_\_\_\_\_

Registration Status: Expiry Date \_\_\_\_\_ Cert. No. \_\_\_\_\_

Training Certificate received to qualify you to attend this course:

Wood Badge Cert. No. \_\_\_\_\_ Section \_\_\_\_\_ Date issued \_\_\_\_\_

ALT Cert. No. \_\_\_\_\_ Date \_\_\_\_\_ LT Cert. No. \_\_\_\_\_ Date \_\_\_\_\_

Date filed	Signature of Applicant
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**LOCAL COUNCIL OFFICE ACTION**

After verification of the above information, we hereby recommend the acceptance of the above-named Scouter to attend the aforementioned course.

\_\_\_\_\_  
Deputy Council Scout Commissioner for Training

\_\_\_\_\_  
Scout Executive/OIC

Date \_\_\_\_\_

Date \_\_\_\_\_

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**REGIONAL OFFICE ACTION**

Verified: \_\_\_\_\_

Endorsed: \_\_\_\_\_

Regional Scout Director

Date: \_\_\_\_\_

Date: \_\_\_\_\_

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**NATIONAL OFFICE ACTION**

Processed by: \_\_\_\_\_

Approved: \_\_\_\_\_

Director, Field Operations Division

Date: \_\_\_\_\_

Date: \_\_\_\_\_

Revised: March 2010

**HEALTH AND MEDICAL RECORD**

This health and medical record, including limitations indicated, is valid for participation in the Scouting Program for one year date of physician's examination subject to recertification in camp and when required for special events.

**Please fill out completely**

**HEALTH HISTORY**

**Have or subject to (check if yes):**

<input type="checkbox"/> Fainting Spells	<input type="checkbox"/> Palpitation	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Headache	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Frequent Cough	<input type="checkbox"/> Easy Fatigue	<input type="checkbox"/> Frequent Fever
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Others _____			

Describe: \_\_\_\_\_

**Have or subject to trouble with (check if yes):**

<input type="checkbox"/> Eye, Ear, Nose, Throat	<input type="checkbox"/> Hernia	<input type="checkbox"/> Allergy	<input type="checkbox"/> Measles	YEAR _____
<input type="checkbox"/> Recurrent Diarrhea	<input type="checkbox"/> Heart	<input type="checkbox"/> Lungs	<input type="checkbox"/> Mumps	_____
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Kidney	<input type="checkbox"/> Malaria	<input type="checkbox"/> Chicken Pox	_____
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Whooping Cough			_____

Any condition now requiring regular medication? \_\_\_\_\_

Any restriction of activity for medical reasons? \_\_\_\_\_

Explain \_\_\_\_\_

**IMMUNIZATION**

Smallpox	Date of last inoculation _____	Polio (Short or Oral)	Date of last inoculation _____
Diphtheria	_____	Others	_____
Tetanus Toxoid	_____		

If applicant is under 21 years of age:

In the event of illness or injury occurring to my son during his attendance at the Jamboree / Training, I do hereby consent to advance to whatever medical or surgical diagnostic procedure or treatment is considered necessary in the best judgement of the attending physician and performed by or under the supervision of a member of the medical staff furnishing medical services. I understand that, in the event of a serious illness or injury, reasonable efforts to reach me will be attempted.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_ Approved by: \_\_\_\_\_  
 Applicant Parent or Guardian

**MEDICAL EXAMINATIONS**

**TO THE PHYSICIAN:** Your careful examination and written recommendation will encourage personal fitness and safe participation in strenuous outdoor activities. Review health history. If incomplete, please ask that this essential information be provided for your use.

**PHYSICAL FINDINGS**

Normal		Abnormal	Explanation if abnormal
<input type="checkbox"/>	Eyes	<input type="checkbox"/>	_____
<input type="checkbox"/>	Vision	<input type="checkbox"/>	_____
<input type="checkbox"/>	Ears	<input type="checkbox"/>	_____
<input type="checkbox"/>	Nose	<input type="checkbox"/>	_____
<input type="checkbox"/>	Throat	<input type="checkbox"/>	_____
<input type="checkbox"/>	Teeth	<input type="checkbox"/>	_____
<input type="checkbox"/>	Lungs	<input type="checkbox"/>	_____
<input type="checkbox"/>	Heart	<input type="checkbox"/>	_____
<input type="checkbox"/>	Blood Pressure	<input type="checkbox"/>	_____
<input type="checkbox"/>	Abdomen	<input type="checkbox"/>	_____
<input type="checkbox"/>	Hernia	<input type="checkbox"/>	_____
<input type="checkbox"/>	Genitalia	<input type="checkbox"/>	_____
<input type="checkbox"/>	Extremities	<input type="checkbox"/>	_____
<input type="checkbox"/>	Posture (Spine)	<input type="checkbox"/>	_____
<input type="checkbox"/>	Skin	<input type="checkbox"/>	_____
<input type="checkbox"/>	Urinalysis	<input type="checkbox"/>	_____
<input type="checkbox"/>	Emotional Stability	<input type="checkbox"/>	_____

**IMMUNIZATION (See history)**

	(Check One)		Date Given
	OK	Needed	
Smallpox	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diphtheria	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tetanus Toxoid	<input type="checkbox"/>	<input type="checkbox"/>	_____
Polio	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cholera / Dysentery / Typhoid	<input type="checkbox"/>	<input type="checkbox"/>	_____

I certify that I have reviewed the health history and examined this person and find him physically fit to participate in:

Camping & Hiking       Water Sports       Competitive Sports

Recommendations and/or restrictions (if none, so state): \_\_\_\_\_

Signed: \_\_\_\_\_ Signed: \_\_\_\_\_  
 Examinee Physician and License No.