

NATIONAL SERVICE TEAM APPLICATION FORM
12th NATIONAL ROVER MOOT

CAMP RODRIGUEZ SANTOS, CADLAN-PALESTINA, PILI, CAMARINES SUR • 23 – 29 OCTOBER 2017
THEME: "GROWTH AND STABILITY"

Name _____
Family Name Given Name Middle Name

Present Address _____
Email Address _____ Contact # _____
Date of Birth _____ Place of Birth _____ Age _____
Religion _____ Civil Status _____ Gender _____
Educational Attainment _____ Occupation _____

Council _____ Region _____
Sponsoring Institution _____
Unit # _____ Membership Card # _____ Date of Registration _____
Present Scouting Position _____

Honorable Charge/Appointment _____
BTC No. _____ ATC No. _____ CML No. _____ CMT No. _____
Section (please put a ✓) ☐ Kawan ☐ Troop ☐ Outfit ☐ Circle ☐ LOA

Council/Regional/National/International Training and Seminars Attended (Title, Date, Venue)

Please give us more information about your knowledge and experiences:

- | | | |
|---|--|--|
| <input type="checkbox"/> Peace Education | <input type="checkbox"/> Rock Climbing | <input type="checkbox"/> Environment Education |
| <input type="checkbox"/> Hiking | <input type="checkbox"/> Run Group Activities | <input type="checkbox"/> Canoeing/Rowing |
| <input type="checkbox"/> Administration | <input type="checkbox"/> Handicrafts | <input type="checkbox"/> Swimming |
| <input type="checkbox"/> Nature Study | <input type="checkbox"/> Outdoor Activities | <input type="checkbox"/> Religious Activities |
| <input type="checkbox"/> Orienteering | <input type="checkbox"/> Photography | <input type="checkbox"/> Pioneering |
| <input type="checkbox"/> Robotics | <input type="checkbox"/> Music (play instrument) | <input type="checkbox"/> Crowd Management |
| <input type="checkbox"/> Public Relations | <input type="checkbox"/> Snorkelling | <input type="checkbox"/> Lifeguard |
| <input type="checkbox"/> Computer and ICT | <input type="checkbox"/> Exhibition Operating | <input type="checkbox"/> Biking |
| <input type="checkbox"/> Performing Arts | <input type="checkbox"/> Journalism | <input type="checkbox"/> Rappelling |
| <input type="checkbox"/> Human Rights | <input type="checkbox"/> Traffic and Security | <input type="checkbox"/> Health Education |
| <input type="checkbox"/> First Aid | <input type="checkbox"/> Radio Operator | <input type="checkbox"/> Warehouse/Stockroom |
| <input type="checkbox"/> Basic Life Support | <input type="checkbox"/> Safety and Risks | <input type="checkbox"/> Logistics |
| <input type="checkbox"/> Messenger of Peace | <input type="checkbox"/> SWA | <input type="checkbox"/> WSEP/Scouts Go Solar |

CERTIFICATION

I hereby certify to the correctness and truthfulness of the information stated above.

Applicant's Signature over Printed Name

ENDORSEMENT OF THE LOCAL COUNCIL

Date _____
Remarks _____

Council Scout Executive/Officer-in-Charge

ENDORSEMENT OF THE REGIONAL OFFICE

Date _____
Remarks _____

Regional Scout Director

ACTION OF THE NATIONAL OFFICE

Date _____ Received _____
Verified: _____ Recorded: _____

☐ Approved ☐ Disapproved ☐ Others

Assistant Project Officer for Administration

12th NATIONAL ROVER MOOT
HEALTH AND MEDICAL RECORD

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:						

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

<input type="checkbox"/>	Eye, Ear, Nose, Throat	<input type="checkbox"/>	Hernia
<input type="checkbox"/>	Recurrent Diarrhea	<input type="checkbox"/>	Heart
<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	Kidney
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Whooping Cough

Have had: (check if yes)

<input type="checkbox"/>	Measles
<input type="checkbox"/>	Mumps
<input type="checkbox"/>	Chicken Pox

YEAR

Any condition now requiring regular medication? _____
Any restriction of activity for medical reasons? _____
Explain _____

IMMUNIZATION

Date of last inoculation

Smallpox	_____
Diphtheria	_____
Tetanus Toxoid	_____

Polio (Short or Oral)
Others

Date of last inoculation

If applicant is under 18 years of age: In the event of illness or injury occurring to my son/daughter during his attendance at the Jamboree, I 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.