

Wilderness Rendezvous Application Form 2025

Name _____
Address _____
City _____ Prov ____ Postal Code _____
Phone _____ Birth Date _____
Provincial Health # _____ Exp Date _____
Troop # & name _____
Next of Kin _____
Signature of Parent/Guardian _____
Address (if different) _____
City _____ Prov ____ Postal Code _____ Phone _____

T-shirt Size _____ Hat Size _____
Sizes T-Shirts Y-M, Y – L, Y-XL, A-M, A-L, A-XL, A-2XL, A-3XL Hats Y-S/M Y-L/XL, A-S/M, A-I/XL

This part is to be filled in by the Troop Scouter

Troop Attending with _____
Cub ____ Scout ____ Venturer ____ Rover ____ Leader ____ Parent Helper ____
Have they ever Attended Wilderness Rendezvous before? Yes, ____ No ____
If yes, did they participate?
Kit ____ Pioneer ____ 1st yr. ____ 2nd yr. ____ 3rd yr. ____ 4th yr. ____ Rovers ____ Sting ____
This youth will be enrolling in
Kit ____ Pioneer ____ 1st yr. ____ 2nd yr. ____ 3rd yr. ____ 4th yr. ____ Rovers ____ Sting ____
This applicant is a registered member of Scouts Canada Yes, ____ No ____
I have 1st Aid Training. Yes, ____ No ____ Type, exp Date

Signature of Scouter _____
Scouter's email _____

Early Bird Registration Deadline May 1st, 2025

Mail Application & Medical Form & payment with all required forms to:

**Wilderness Rendezvous
115 – 2825 Meadows Parkway
Saskatoon, SK S7V 0Y3**

Or Email to wildernessrendezvous@gmail.com

**Make cheque payable to Wilderness Rendezvous or
Send an e-transfer to wildernessrendezvous@gmail.com**

Additional Medical & Allergy Information

Name _____
Address _____
City _____ Prov _____ Postal Code _____
Phone _____ Birth Date _____
Age _____ Male _____ Female _____
Provincial Health # _____ Exp Date _____
Physician's Name _____ Phone # _____
Emergency Contact Name _____ Phone # _____

Do you require special care, medication, or diet? Yes, _____ No _____

If yes, why? _____

Do you have allergies? Yes, _____ No _____ How severe? _____

Type & cause of reaction? _____

Medicine _____ Insect Bite _____ Food _____ Smoke _____ Plants _____ Animals _____ Other _____

*For Food allergies, our staff will contact you

Indicate (X) if you have had Appendicitis _____ Mumps _____ Chicken Pox _____ Measles _____

Kidney Disease _____ Rheumatic Fever _____ Heart Condition _____ Other _____

Details _____

Indicate (X) if you have any of the following and give details:

Braces _____ Contact Lenses _____ Headaches _____ Fainting Spells _____

Bleeding Disorders _____ HIV _____ Hernia _____ Back Problems _____ Motion Sickness _____

Cramps _____ Convulsions _____ Sleep Walking _____ Ear Problems _____ Diabetes _____

Nightmares _____ Asthma _____ ADHD _____ Other _____

Details _____

Date of your most recent Physical examination (Month/Year) _____

Date of your most recent tetanus shot (Month/Year) _____

Has it ever been necessary to restrict your activities for medical reasons? Yes _____ No _____

Details _____

If female, has the youth participant menstruated? Yes, _____ No _____

If not, has she had menstruation explained to her? Yes, _____ No _____

Parent/Guardian Signature

Date
