

PARENT OR GUARDIAN CONSENT AND APPROVAL FOR SCOUT ACTIVITY

(Applies to all personnel under the age of 18)

SCOUT NAME: _____

ADDRESS: _____

CITY/STATE/ZIP _____

BIRTH DATE: _____ / _____ / _____ Month/Day/Year HOME PHONE: (____) _____

Has my permission to participate in: _____

at: _____

To be held on the following dates: From : _____ / _____ / _____ through _____ / _____ / _____

I approve of the leaders who will be in charge of this activity. I certify that my son is in good health and suffering no illness, disabilities or limitations that would endanger his health or safety on the activity described above.

AUTHORIZATION AND CONSENT TO TREAT A MINOR

My son has reviewed his equipment checklist in his Scout Handbook and I am satisfied that he is properly dressed and equipped for this activity. I understand that all troop activities are conducted in the spirit of the Scout Oath & Law. Any scout who, in the opinion of the adult leadership, does not live up to these principles may be required to call me and have me take him home.

In the event of an injury, accident or sickness of my son while participating in a Boy Scouts of America/Troop 915 activity, I authorize an adult leader of Troop 915 Boy Scouts of America, to obtain any such emergency medical, dental or vision treatment as may be required. I also give my consent for my son to receive blood transfusions should it be deemed necessary to sustain his life and/or well-being. I further agree that I will accept financial responsibility for any medical treatment provided. In consideration of benefits to be derived and in view of the fact the Boy Scouts of America is an educational institution, which is voluntary, and having full confidence that every precaution will be taken to insure safety and well-being of my son, I hereby agree to my son's participation and waive all claims against the leaders of this activity and officers, agents and representatives of Troop 915 and the Boy Scouts of America.

Parent/Guardian Signature: _____ **Date:** _____

IN CASE OF EMERGENCY, PLEASE NOTIFY:

Emergency Contact Person/Name _____ Health Insurance Company _____ Physician Name/Medical Group _____

Home Address _____ Claims Address _____ Office Address _____

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Home Phone Cell Phone Phone (As it appears on Ins. Card) Office Phone

() - () - _____
Work Phone Alternate Phone Policy #, Group# or Plan# Date of Last Tetanus

Please list any allergies or other medical conditions that warrant notification. Use the back of this form (if necessary) if there is any activity he may not participate in. _____

Please list any medications your son is currently taking: _____

This form must be signed and returned to the adult leader before the Scout will be permitted to participate in the activity.

This form is required for all trips.