

Scout Name: \_\_\_\_\_ Date: \_\_\_\_\_

## Permission Form

Activity: \_\_\_\_\_

Location: \_\_\_\_\_

Dates: \_\_\_\_\_

Sponsor: \_\_\_\_\_

In consideration of the benefits to be derived, and in view of the fact that the Boy Scouts of America is an educational institution, membership in which is voluntary, and having full confidence that every precaution will be taken to ensure the safety and well being of my Scout son/ward, namely:

(PLEASE PRINT) \_\_\_\_\_,

On the activity named above, I agree to his participation and waive all claims against the leaders of this trip, officers, agents and representatives of the Boy Scouts of America and the sponsor. Further, I understand my responsibility for this scout's actions at all times on this activity.

In the event of an emergency, the troop unit leader of the activity has my permission to obtain medical treatment for this Scout at the nearest hospital or doctor, at my expense, if our own doctor is not readily available. During this activity I (or my authorized representative) can be contacted at the following phones, and will accept long distance collect calls:

(\_\_\_\_\_) \_\_\_\_\_

(\_\_\_\_\_) \_\_\_\_\_

If at any time there is a disciplinary problem with this scout, I may be contacted at the above numbers, and I will pick him up if requested.

For this activity, if needed, I will:

Drive     Help buy supplies

Camp     Provide no service

\_\_\_\_\_  
(Signature of Parent or Guardian)

\_\_\_\_\_  
(Date)

Scout Name: \_\_\_\_\_ Date: \_\_\_\_\_

### MEDICAL AND INSURANCE INFORMATION

Is this scout's current medical form on file? \_\_\_\_\_

Is this scout presently on medication or under a doctor's care? \_\_\_\_\_

If so, do you want the unit leader to carry the medication? \_\_\_\_\_

Will he require medication on the outing? \_\_\_\_\_  
(If so, describe on back of this form)

Is this Scout allergic or sensitive to anything? \_\_\_\_\_  
(If so, describe on back of this form, indicating severity)

Also, use the back of this form for additional information and for explanations of any other problems of which the unit leader should be aware.

Date of most recent tetanus shot/booster: \_\_\_\_/\_\_\_\_/\_\_\_\_

INSURANCE COMPANY \_\_\_\_\_

POLICY # \_\_\_\_\_

CONTROL # (IF ANY) \_\_\_\_\_

OTHER INFORMATION: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
(Signature of Parent or Guardian)

\_\_\_\_\_  
(Date)