CUB SCOUT PACK 889

Naperville, IL

PARENT CONSENT/PERMISSION FORM

***Name of Scout*:** _____

Description of Activity:

Date and Time:

In consideration of the benefits to be derived, and in view of the fact that Boy Scouts of America is an educational organization, membership in which is voluntary, and having full confidence that every precaution will be taken to ensure the safety and well being of my son(s)/ward(s) during this activity or trip, I hereby agree to his (their) participation and waive all claims against the leaders of this activity or trip, officers, agents, and representatives of the Boy Scouts of America.

In case of Emergency, I understand every effort will be made to contact me. In an event that I cannot be reached, I hereby give my permission to the physician selected by the adult leader in charge to secure proper treatment which may include dentistry, hospitalization, anesthesia, surgery, or injections of medication for the above mentioned Scout at the nearest hospital or doctor/dentist.

Parent or Guardian's s Name:
(please print legibly) _____

Signature: _____

Address: _____

_____

In an emergency, I can be reached at any time during this activity at the following phone numbers:

( ) _____ ( ) _____ ( ) _____

In the event of an emergency, or need for medical treatment, the troop unit leader of the activity has my permission to obtain medical treatment for the above-mentioned Scout at the nearest hospital or doctor, at my expense, if our doctor is not readily available, and as restricted on the Emergency Data Sheet on file with the Troop, or as indicated below.

Signature of Parent or Guardian and Date: _____

Name of family doctor *and* phone number: _____

This Scout is highly sensitive or allergic to: _____

What, if any, medication is this Scout taking? _____

Any special instructions for this medication? _____

The adult leader in charge is required to be advised and reserves the final authority to carry and administer this medication. Please use the space below for additional medical information the activity leader should be aware of.

Medical Insurance Information:

Company: _____ Policy Number: _____

Control No.: _____ Other: _____