

ACTIVITY PERMISSION

THIS FORM & YOUR SON'S MONEY MUST BE RETURNED TO THE TROOP MEETING PRIOR TO THE ACTIVITY IF HE IS GOING!

ACTIVITY:

Time & Date of Departure:

Time & Date of Return:

Cost:

Where:

Emergency Phone Number: Annette Crowley 817-726-9445, 817-473-4122

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WAIVER OF RESPONSIBILITY

*****RETURN THIS PORTION WITH YOUR MONEY BY**

DATE _____

TROOP 215

BOY SCOUTS OF AMERICA

Trinity Presbyterian Church

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 reasonable precaution will be taken to ensure the safety and well being of my son(s)/ward(s), namely _____ on the activity named below, I agree to his participation and waive all claims against the leaders of this troop, officers, agents, and representatives of the Boy Scouts of America, and the sponsor.

In the event of an emergency, the troop unit leader of the activity named below 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.

Signature of parent/guardian

Date

Activity

EMERGENCY INFORMATION

During the activity listed above, I can be contacted at the following phone numbers and will accept long distance calls at (____) ____-____ or if I cannot be reached in case of an emergency call _____ at (____) ____-____.

This Scout is highly allergic or sensitive to: _____

Date of most recent tetanus shot/booster: _____

Medication this Scout is taking: _____

Special instructions for this medication: _____

Medications should be given to the Unit Leader to carry.

Medical Insurance information:

Company _____ Policy No. _____ If Group Policy, Control No. _____

I am willing to help provide transportation for this activity: YES NO

If yes, number of boys I can carry: 1 2 3 4 5 6 7 8 9 10