BSA Pack _____

Black Swamp Area Council BSA

PERMISSION SLIP AND/OR WAIVER OF RESPONSIBILITY

Activity:_____ Location: _____

Departure date: _____ Return Date: _____ Activity Leader: _____

PLEASE FILL OUT FORM IN FULL

PACK SUPPORT: Can parent help to transport to site? No Yes ..... from site? No Yes

Vehicle:_____ Ins. Co.:_____ DL#_____ # Boys you can carry: _____.
year / type Seat belt per boy a must!

Name of Adult Camper(s): _____ Phone: _____

PARTICIPATION WAIVER for my son, namely: _____ from Pack _____

In consideration of the benefits to be derived, and since 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, named above on the activity identified 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.

Upon an emergency, illness, or accident during the activity identified above, I understand every effort will be made to contact me. In the event that I cannot be reached in a timely manner and our own doctor is not readily available, the troop or unit leader of the activity identified above has my permission to obtain without delay medical treatment as judgment of medical personnel dictates. Proper medical treatment may include hospitalization, anesthesia, surgery, or injections of medication for my son.

Signature of Parent or Guardian: _____ Date: _____

Printed Signature of Parent or Guardian: _____

EMERGENCY INFORMATION: (Required update for troop Health and Medical Records).

During the activity identified above, We/ I can be contacted at the following phone/ locations:

(____)_____/_____ or (____)_____/_____. If we/ I can not be reached please
Phone / location phone / location

contact: (name)_____ at (phone)_____ (Relationship to boy)_____

Scout's physician _____ Phone:_____

Scout's Allergies:

_____

Scout's Currently prescribed medication: _____

Instructions for dispensing this medication

_____

Do you want the unit leader to carry this medication? no yes
(Please have medication clearly marked and preferably in original container clearly marked with Scout's name)

Tetanus Shot: Date of last tetanus shot or booster: _____

Family Medical Insurance: Company: _____ Policy # _____ Group # _____

To be completed by Pack Committee Chair:

FEES PAID: Adult food_____ Adult camp fee_____ Scout food_____ Scout Camp fee_____

Received by_____ Date: _____