

WAIVER OF RESPONSIBILITY AND PERMISSION TO TREAT

(Scoutmaster, or designee, to carry one for each Scout)

Troop 927 Boy Scouts of America

Westchester, California

In consideration of the benefits to be derived, and in view of the fact that the Boy Scouts of America is an education 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, namely:

Name of Scout: \_\_\_\_\_ / / \_\_\_\_\_
Date of Birth

On the activity named below, I agree to his/her participation and waive all claims against the leaders of this trip, officers, agents and representatives of the Boy Scouts of America, and the sponsor.

The undersigned does hereby grant Ed Lesnansky or such substitute as he/she
Unit Leaders

may designate as agent for the undersigned to consent to any X-ray, examination, medical, dental or surgical diagnosis or treatment and hospital care for the above minor which is deemed advisable and to be rendered under the general or special supervision of any physician or surgeon, licensed under the Provision of Medicine Practice Act or of any dentist licensed under the Dental Practice Act, whether such diagnosis or treatment is rendered at the office of said physician or dentist, at a hospital, event site, or elsewhere.

This authorization will remain effective while the above minor is en route to and from or involved or participating in any Boy Scout/Varsity/Explorer Scout program or activity, unless revoked in writing by the undersigned and delivered to the aforesaid agent.

ACTIVITY: Game Night, January 27-28, 2012

Signature of parent or guardian Date

EMERGENCY INFORMATION

(In addition to Personal Health and Medical Record)

During the activity listed above, I can be contacted at the following phones:
( ) \_\_\_\_\_ Or ( ) \_\_\_\_\_

This Scout is highly allergic or sensitive to: \_\_\_\_\_

What, if any, medication(s) is this Scout taking?: \_\_\_\_\_

Any special instructions/needs for this medication(s)?: \_\_\_\_\_

Do you want the unit leader to carry the medication? YES NO

Use the back of this form for additional information and for explanation of any other problems the activity unit leader should be aware of.

Check here if additional information on back.

Date of last tetanus shot/booster \_\_\_\_\_

Medical Insurance Information

Company: \_\_\_\_\_

Policy number: \_\_\_\_\_

ID number: \_\_\_\_\_

Group Number: \_\_\_\_\_

Insurance Company Phone: ( ) \_\_\_\_\_

Doctor/Medical Group Phone Number: ( ) \_\_\_\_\_