Troop 624 Parental Permission/Release/Medical Treatment Form

I give permission for my son(s)_____
to attend a BSA Troop 624 sponsored event at Camp Wilson for the **Chain Bridge District Projectoree** on **April 27-29, 2018**. In the case of injury or illness, I authorize Troop 624 to render emergency first aid and/or seek all necessary medical attention for my son. In such cases, I understand that I will be notified as soon as possible. I certify that my son possesses no physical condition which precludes his full participation in activities associated with this event except for the conditions, allergies or precautions listed on the reverse of this form and/or on the accompanying emergency medical treatment form. I understand that medical personnel and first aiders will rely on the completeness of the accompanying medical information I have provided.

Express Liability Waiver: I understand that outdoor and sports activities inherently involve risks that can result in serious injury; I hereby assume the risk for all such hazards, and agree to hold harmless and blameless the leadership of Troop 624 (including members of Troop 624's committee and any adults participating in or providing assistance to the activity) and St. Ann Parish in the event of any injury or illness resulting from my son's participation in this activity.

In case of an emergency during this activity, please contact:

_____ _____
Name Phone Number(s)

Alternate (in case above cannot be reached):

_____ _____
Name Phone Number(s)

_____ _____
Parent or Guardian Date

Troop 624 Emergency Medical Treatment Form for Scouts

Emergency Treatment Release Statement: I hereby authorize Troop 624's Adult Leadership and/or any licensed physician, EMT or other qualified hospital personnel to render medical treatment to my son _____ which, in their judgment, is necessary in the event of illness or injury. I understand that, in all such cases, I will be notified as quickly as possible.

_____

(Signature of Parent or Guardian) (Date)

Scout's Full Name: _____

Date Of Birth: _____

Full Address: _____

_____

Home Phone Number: _____

Father's Work Number: _____

Mother's Work Number: _____

Additional Permanent Emergency Number: _____

Name of person to contact at this additional number: _____

Relationship to Family: _____

Please list any and all allergies, special medical conditions, special medications or health problems a first aider or medical practitioner should be aware of prior to treatment:

_____

_____

_____

Please list any and all medications that your son takes on a regular basis. Please include amounts taken, number of daily doses and routine administration times:

_____

_____

_____

Are there any medications that you know of that are contraindicated for medications your son is currently taking on a regular basis?

_____

_____

Blood type (if known): _____

Does your son wear contact lenses?: _____

Name of Family Doctor: _____

Office Phone Number: _____

Emergency Phone Number: _____

Medical Insurance Policy Name and Number: _____

_____

Emergency (or Prior Approvals) Phone Number: _____