

BOY SCOUTS OF AMERICA
S.E. LOUISIANA COUNCIL
TROOP 64 – PERMISSION SLIP

SCOUT'S NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ PHONE #: _____

_____ CELL #: _____

PARENT'S NAME: _____ EMERGENCY PHONE NUMBER: _____

DOCTOR'S NAME: _____ EMERGENCY PHONE NUMBER: _____

FAMILY MEDICAL / HOSPITAL INSURANCE: _____

COMPANY: _____

POLICY NO.: _____ GROUP NO. : _____

ALLERGIES: _____

OTHER MEDICAL CONDITIONS: _____

I give my permission for my son _____ to participate in all troop activities and outings. I am fully aware that there is always some risk associated with these activities and outings.

In the event of an emergency, I give my permission to the troop leaders to administer first aid and, when necessary, seek further medical assistance. In such cases, I give my permission to the medical personnel to treat, hospitalize, secure proper treatment, order injections, transfusions, anesthesia or surgery for my son when required.

I am aware that the troop has a supplemental accident insurance policy with the "Boy Scouts of America Council Accident & Sickness Insurance Plan" and Health Special Risk, Inc. of Carrollton, TX. I agree to be fully responsible for all costs incurred which are not covered by the troop policy or the family policy listed above.

THIS PERMISSION SLIP IS VALID FROM JANUARY 1, 2009 THRU DECEMBER 31, 2009.

PARENT/GUARDIAN DATE

SCOUTMASTER COMMITTEE CHAIRMAN