Scout Permission Slip

Activity Name: _____

For activity dating from _____ to _____

Address: _____

City _____ State _____ Zip _____

Health/Accident Insurance Co:: _____

Policy Number: _____

Have or subject to (check if yes):
❑Asthma ❑Fainting Spells ❑Convulsions ❑Allergy to any medication, food ❑Any condition that may require

Special care, medication (check if yes):
❑Diabetes ❑Heart Trouble ❑Bleeding Disorders ❑Plant, ❑Animal, or ❑Insect toxin

Explain: _____

_____

❑ Check here if none of the above applies

Have difficulty with (check if yes) ❑Eyes, ❑Ears, ❑Nose, ❑Throat ❑Digestion ❑Bed-wetting ❑Lung ❑Sleep walking

❑ Any condition now requiring regular medication?

Name of Medication(s): _____

❑ Any restriction of activity for medical reasons? _____

Explain: _____

Parent Authorization

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed activities, except as noted by me. In the event I cannot be reached in an emergency, I hereby give permission to the physician, selected by the adult leader in charge, to hospitalize, secure proper anesthesia, or to order injection for my son.

I will not hold Boy Scouts of America or any of their representatives, including but not limited to, Adult members of _____, Council Representatives, Sponsoring Institution,... liable for my son/daughter's actions.

_____ _____
Signature Date

Home Telephone Number: _____ Work Telephone Number: _____

Name and telephone number of relative or neighbor: _____

I authorize ONLY the following people to remove my son from the activity site: (Name and Relationship): _____

_____

_____