

# Troop 672 Parent/Guardian Permission Slip

Scout Name: \_\_\_\_\_

Activity Name: \_\_\_\_\_

For Activity Dating From \_\_\_\_\_ to \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Health/Accident Insurance Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Have or subject to (check if yes):

- Asthma  Fainting Spells  Convulsions  Allergy to any medication or food  
 Any condition/injury that we should be aware of

Special care, medication (check if yes):

- Diabetes  Heart Trouble  Plant  Animal  Insect Toxin  Other

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 and description of medication(s): \_\_\_\_\_

When was last dose given and at what intervals should each medication be given? \_\_\_\_\_

Any restriction of activity for medical reasons? \_\_\_\_\_

Explain: \_\_\_\_\_

## Parent Authorization

The 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 even 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 the Boy Scouts of America or any of their representatives, including but not limited to, Adult members of Troop 672, Council or District representatives, or American Legion Post 276 liable for my son's actions.

\_\_\_\_\_  
Signature Date

Home Telephone Number: \_\_\_\_\_ Cell 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):

\_\_\_\_\_