

Boy Scout Troop 806

ARROHATTOC DISTRICT, HEART OF VIRGINIA COUNCIL OF THE BSA
WOODLAKE UNITED METHODIST CHURCH, SPONSOR
JEFF DEHOFF, SCOUTMASTER

PERMISSION SLIP AND/OR WAIVER OF RESPONSIBILITY

Activity : _____ Location: _____

Departure Date: _____ Return Date: _____ Activity Leader: _____

PLEASE FILL OUT FORM IN FULL

NAME OF SCOUT CAMPER: _____

Name(s) of Adult Camper(s): _____ Phones: Home #: _____ Cell#: _____

Name(s) of Additional Family members Camping: _____

TROOP SUPPORT: Can parent help to transport to site? Yes: _____ No: _____ From Site? Yes: _____ No: _____

Vehicle (year/make): _____ Ins. Co.: _____ # Number of Seats In Vehicle: _____ (**NOTE: A seat belt per rider is required!**)

Liability Insurance Coverage: Each person \$ _____ Each accident: \$ _____ Property Damage: \$ _____

PARTICIPATION WAIVER for my son/ward, namely: _____ from the _____ Patrol. In consideration of the benefits to be derived, and since the Boy Scouts of America is an educational 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 son/ward, named above on the activity identified above, I agree to his participation and waive all claims against the leaders of this trip, officers, agents, and representatives of the Boy Scouts of America, and the Sponsor, Woodlake United Methodist Church and its associations.

Upon an emergency, illness, or accident during the activity identified above, I understand every effort will be made to contact me. In the event that I cannot be reached in a timely manner and our own doctor is not readily available, the troop or unit leader of the activity identified above has my permission to obtain without delay medical treatment as judgment of medical personnel dictates. Proper medical treatment may include hospitalization, anesthesia, surgery, or injections of medication for my son/ward.

Signature of Parent or Guardian: _____ Date: _____

Printed Signature of Parent or Guardian: _____

EMERGENCY INFORMATION: (Required update for troop Health and Medical Records).

During the activity identified above, We/I can be contacted at the following phone/ locations:

Home #: _____ Cell #: _____ or Alt#1: _____ Alt # 2: _____. If we/I can not be reached,

Alt. Contact: (name) _____ / (_____) _____ (Relationship To Scout) _____

Scout's physician _____ Phone: _____

Scout's Allergies: _____

MEDICATION: IF ANY SCOUT NEEDS TO TAKE MEDICATION OF ANY KIND DURING THE CAMPOUT, THE MEDICATION MUST BE HAND-DELIVERED BY THE PARENT TO THE MEDICINE STAFFER BEFORE LEAVING WUMC. ALL MEDICATION MUST BE IN A ZIPLOCK BAG, CLEARLY LABELED WITH ADMINISTERING INSTRUCTIONS—NO EXCEPTIONS!!****

Scout's currently prescribed medication: _____

Medicine Staffer: _____ Date of last tetanus shot or booster: _____

Family Medical Insurance: Company: _____ Policy # _____ Group # _____

To be completed by troop scribe:

FEES PAID: Adult food: _____ Adult Camp Fee: _____ Scout Food: _____ Scout Camp fee: _____

Received By: _____ Date: _____

Prescription Medication Information Form

SCOUT NAME: _____ DATE TO BE GIVEN: _____

MEDICATION: _____ DOSAGE: _____

Specific Instruction for dispensing medication: _____

PARENT SIGNATURE: _____ DATE: _____

Home #: _____ Cell #: _____ or Alt#1: _____ Alt # 2: _____.

A SEPARATE FORM MUST BE FILLED OUT FOR EACH MEDICATION

Prescription Medication Information Form

SCOUT NAME: _____ DATE TO BE GIVEN: _____

MEDICATION: _____ DOSAGE: _____

Specific Instruction for dispensing medication: _____

PARENT SIGNATURE: _____ DATE: _____

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