

Boy Scout Troop 806

ARROHATTOC DISTRICT, HEART OF VIRGINIA COUNCIL OF THE BSA
WOODLAKE UNITED METHODIST CHURCH, SPONSOR
MICHAEL PACE, SCOUTMASTER

PERMISSION SLIP AND/OR WAIVER OF RESPONSIBILITY – VENTURE PARTICIPATION

Activity: **Venture Shooting Trip**

Location: **Amelia Shooting Range**

Departure Date: **Oct 21st, 12:30PM**

Return Date: **Oct 21st, 3:30-4:00pm**

Activity Leader: **Mr Gibbs**

PLEASE FILL OUT FORM IN FULL

Name of Venture Scout: _____ Phone: _____

Name of Adult : _____ Phone: _____

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:

(_____) / _____ or (_____) / _____. If we/ I can not be reached,
phone / location phone / location

Contact: (name) _____ / (_____) _____ (relationship to boy) _____

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 WOMAN BEFORE LEAVING WUMC. ALL MEDICATION MUST BE IN A ZIPLOCK BAG, CLEARLY LABELED WITH ADMINISTERING INSTRUCTIONS—NO EXCEPTIONS!!

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

To be completed by Coordinator

FEES PAID: SHOOTING FEE \$5 _____ DATE RECEIVED: _____