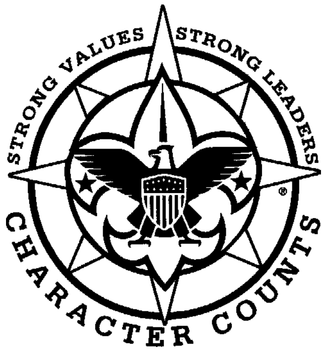

Scout Permission Slip

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): __________________

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