

PERMISSION SLIP TROOP 246

EVENT NAME: _____ **DATES:** _____

ADULT CAMPMASTER: _____ **PHONE:** _____

LOCATION: _____ **CAMPSITE:** _____

DEPARTURE: _____ **RETURN:** _____

COST PER SCOUT: \$ _____

FYI _____

MAKE SURE TO BRING: _____

------(detach here—provide bottom portion to adult Campmaster)-----

ACTIVITY CONSENT FORM & HOLD HARMLESS AGREEMENT

I hereby give my permission for _____ to attend the
_____ activity on _____ with the following restrictions:

- Without restrictions
- Special considerations or restrictions: _____

I acknowledge an up-to-date medical form for my child is on file with Troop 246. I authorize the adult Campmaster or designated adult assistant to administer medications as indicated below. I understand that participation in this activity is entirely voluntary and requires participants to abide by applicable rules and standards of conduct. I have discussed appropriate behavior for this activity with my child and I understand that I will be called to take my child home prior to the conclusion of the activity if his behavior is deemed inappropriate by the adult Campmaster. I further understand that participation in this activity involves a certain degree of risk. I have carefully considered the risk involved and authorize my child to participate fully, with restrictions noted above. I release the Boy Scouts of America, the Miami Valley Council, Troop 246 including its chartering organization—Englewood UMC, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with the activity from any and all claims or liability arising out of this participation. In case of emergency involving my child, I understand every effort will be made to contact me. In the event I cannot be reached, I hereby give my permission to the medical provider selected by the adult Campmaster or designated adult assistant to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child. Medical providers are authorized to disclose to the adult-in-charge examination findings, test results, and treatment provided for purposes of medical evaluation of my child, follow-up and communication with myself or other family members, or determination of my child's ability to continue in the program activities.

Name: _____ Signature: _____ Date: _____

List all meds (w/dose & freq.) to be taken during event:

NOTE: Please check with Treasurer for available funds before selecting "Account".

Fees Paid:
 Account: \$ _____
 Cash: \$ _____
 Check: \$ _____