

BSA Troop 843 Outing Permission Form

Outing:	Spring Field Days campout
Date(s):	Friday, April 21 through Sunday, April 23, 2006
Location:	Alum Creek State Park Group Camp Area
Cost:	\$3.00 per person
Register by:	Monday, April 3, 2006
ESA:	Joe Nelson, 740-657-8845 or <JosephNelson@insight.rr.com>
Depart from:	Meet at the Group Camp Area (see notes)
Return to:	Pickup at Group Camp Area, Sunday April 23 at 11:00 AM
Notes:	Older Scouts arrive Friday night at 6:00 PM to set up and camp overnight, new Scouts arrive Saturday morning at 11:00 AM. All depart Sunday morning.

Scout Name:	
Parent Name (if attending):	
Drive to event (Y/N)	
Drive from event (Y/N)	
Vehicle and # of seat belts:	
Driver's License #:	
Driver's Licence state:	
Mimimum insurance (Y/N)	

Emergency Contact Information

Parent Name:	
Home Phone:	
Cell/Pager:	
Alternate Contact:	
Home Phone:	
Doctor Name/Phone:	
Dentist Name/Phone:	

Amount paid: \$ _____ by cash, check, scout account (circle one)

Informed Consent, Hold-Harmless Agreement, and Consent for Medical Care

I understand that participation in activities offered through Troop 843, Boys Scouts of America, involves a certain degree of risk. In consideration of the benefits to be derived, and after carefully considering the risk involved, and in view of the fact that the Boys Scouts of America is an organization in which membership is voluntary, and having full confidence that precautions will be taken to ensure the safety and well-being of my son, I give (Scout's name) _____ my consent to participate in the Spring Field Days Campout from Sat. 4/21/06 through Sun. 4/23/06. I discharge and release Troop 843, the Simon Kenton Council, the Boy Scouts of America, and all other organizations or persons connected with this activity from all claims for personal injury, loss or inconvenience resulting from my son's participation. I further understand that, in case of emergency, every effort will be made to contact me. In the event I cannot be reached, I hereby give my permission to the licensed health-care practitioner selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my son. This form must have both parent's/guardian's signatures.

Name (please print)

Name (please print)

Signature

Signature

Date

Date

Telephone number with area code

Telephone number with area code