

**Kalhaven Trail Bike Hike
 Oct 24 - 26, 2003
 South Haven, Michigan
 B. S. A. TROOP 23
 PERMISSION SLIP**

My son, _____, has permission to participate in the Kalhaven Trail Bike Hike and Camp Outing on Oct 24-26, 2003. I am familiar with the details of this activity. I will be certain that he does not go if he is not in good physical condition and good health. In consideration of the services donated by others, I will hold free from all liability, in case of accident or illness, Boy Scout Troop #23, Mt. Prospect, Illinois. I further understand and agree that any serious infraction (s) of camp or troop rules by my son could result in his dismissal from the aforementioned activity. Return transportation under such circumstances will be my responsibility.

During this activity I can be reached at:

| Name | Location | Phone Number | Alternate Phone Number |
|-------------------|--------------|--------------|------------------------|
| | | | |
| Emergency Contact | Relationship | Phone Number | Alternate Phone Number |
| | | | |

Date: _____ Signed (X) _____

Will a parent be attending the campout? Yes No Parent Name _____

If attending, can you drive? Yes No Number of Belts _____

If Driving, do you have a CB? Yes No Cellular Phone _____

If you would like to leave early, what time could you leave at? _____

Parent or Guardian

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 TO WHOM IT MAY CONCERN:

As a parent and/or guardian, I do hereby authorize the treatment by a qualified and licensed medical doctor of the following minor in the event of a medical emergency which, in the opinion of the attending physician, may endanger his or her life, cause disfigurement, physical impairment or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me.

Name of Minor: _____ Relationship: _____

Date or dates when release is intended: Oct 24 - 26, 2003.

This release form is completed and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstances in my absence.

Signed (X): _____

Parent or Guardian

Address: _____ Phone: _____

Family Physician: _____ Phone: _____

List any specific medical allergies, chronic illnesses, current medication or other conditions: _____