

**B. S. A. TROOP 23, MOUNT PROSPECT ILLINOIS
PERMISSION SLIP and EMERGENCY MEDICAL FORM
Five Mile Hike
May 9, 2009**

Scout's Name _____ Age _____ Date of birth ____/____/____

Street Address _____ City _____ State _____ Zip _____ Home Phone _____

Parent/Guardian Name _____ Home Telephone _____ Cell (or alternate) Telephone _____ Relationship _____

Emergency Contact Name _____ Home Telephone _____ Cell Number _____ Relationship _____

My son, _____, has my permission to attend the above described activity. I am familiar with the details of the described activity. Before permitting my son to participate, I will ensure that my son is in good physical condition and good health, and I will not permit him to attend if he is not in good physical condition and good health.

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. I understand that return transportation from the aforementioned activity under such circumstances will be my responsibility.

In consideration of the services donated by others, I will hold Boy Scout Troop #23, Mount Prospect, Illinois, their sponsors, Boy Scouts of America, and any and all adult leaders or volunteers present at the aforementioned activity, free from any and all claims and liability, whether known or unknown, for death, personal injury or property damage, arising from accident, illness, injury, damage or other harm or loss and harm to/or incurred or suffered by _____ or to his property, in connection with or incidental to the trip or activity, including preliminary training or travel, including claims and liability arising out of negligence or carelessness of the aforementioned persons or organizations. I further agree to indemnify, hold harmless and agree to defend such persons as to any claim, suit or damages they may be called upon to pay or defend in connection therewith.

Parent or Guardian Signature

Date

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May Day Hike
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TO WHOM IT MAY CONCERN:

In the event of illness or injury occurring to my son, _____, while in this trip or activity, I consent to provision of medical services to my son by qualified medical providers, including emergency personnel, hospitals, medical centers, licensed physicians and medical providers under their instruction and control. Such medical treatment may include first aid, medical examination and/or treatment, including without limitation x-ray examination, anesthesia, and/or medical or surgical diagnostic procedures or treatment considered necessary in the best judgment of the attending physician and performed by or under the supervision of a member of the medical staff of the hospital or facility furnishing medical services.

I hereby consent, agree and approve to all the terms, condition and waiver or claims of this permission form and certify to its correctness.

Primary Physician

Office Telephone

Address

List Allergies

List Medical Condition

Parent or Guardian Signature

Date