

**2003 Blackhawk District Spring Camporee  
 April 11-13, 2003  
 Rainbow Council Scout Reservation, Morris, IL  
 B. S. A. TROOP 23  
 PERMISSION SLIP**

My son, \_\_\_\_\_, has permission to participate in the 2003 Blackhawk District Spring Camporee on April 11-13, 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 you can drive, Please provide your car: Model \_\_\_\_\_, License \_\_\_\_\_

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

**Parent or Guardian**

.....  
 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: **April 11-13, 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: