

BSA TROOP 680 – RANCHO BERNARDO, CA

Activity Permission Slip

Return bottom portion of this form to the Tour Leader. Keep top portion for your reference.

ACTIVITY:				
LOCATION:		DATES:		through
LEADERSHIP INFO	Patrol Contact	Adult #1	Adult #2	In town contact
Name:				
Phone:				
eMail:				
ACTIVITY DETAILS	Pre-Meeting	Departure	Return	
Date:				
Location:				
Time:				
Estimated Cost:	Total \$	Travel \$	Meals \$	Other \$
Special Equipment and Notes:				
Uniform:	Class A	Class B	Water:	quarts



I grant permission for Scout _____ to attend the following Scout Troop Activity _____ on _____.

✓ I will see that he is properly equipped for the outing, including the "Ten Essentials-Plus" as appropriate. I understand that the adult leader will enforce reasonable safety precautions, however, I will not hold Boy Scout Troop 680 or any leader connected with that troop responsible in case of an accident or injury to the above named Scout.

✓ The undersigned also authorizes the SCOUTMASTER or TOUR LEADER or such substitute as the Scoutmaster or Tour Leader designates as agent for the undersigned to consent to any medical, dental, or surgical diagnosis or treatment, or hospital care for the above named minor which is deemed advisable by and to be rendered by a licensed physician or surgeon. This authorization will remain effective for the duration (including transportation to and from) of the activity listed above.

✓ This permission slip must be returned to the designated Tour Leader by _____.

_____ Date _____ Phone # _____
 (Parent /Guardian Signature)

Will the Parent/Guardian be going on the above activity? Yes _____ No _____ Alternate Phone# _____

Alternate Contact _____ Phone # _____

MEDICAL INFORMATION: Plan name: _____ Group #: _____
 Member # _____ Doctor's name: _____ Phone# _____

The adult leaders on the outing are not in the position to administer medication. Should medical treatment be required, the doctor will need to be informed of any medical condition, allergy, or use of medication by your son. All such conditions must be noted below. If no medical conditions or use of medications exist, state "NONE".

Allergies: _____ Medications: _____

Special Conditions: _____

(If more room is needed, continue on the back of this form, at the bottom of the sheet)