

# TROOP 671 PARENT / GUARDIAN PERMISSION SLIP

[troop671.ocbsa.org](http://troop671.ocbsa.org) on the Internet

**EVENT: Gold Camp - June 2009**

**DATES:** from **Friday June 19, 2009** till **Sunday June 21, 2009**

**COST: \$ 45 per scout  
Prepaid**

**LOCATION: Camp Williams**

24210 East Fork Road  
Azusa, Ca 91702 6812  
(626) 910-1126

**Closest Hospital:**  
Foothill Presbyterian  
250 S Grand Ave  
Glendora, CA (626) 963-8411

**MEET AT: Saint Hedwig ON: Fri. 6/19/09 AT: 5:30 PM**

**RETURN TO: Saint Hedwig ON: Sun. 6/21/09 AT ABOUT: 1:00 AM**

**SCOUTMASTER / ADULT LEADER: Mr. Greg Shoop/ Craig Fults**

PLEASE RETAIN TOP FOR YOUR RECORDS

MY SON \_\_\_\_\_

**FROM: Fri. 6/19/09 5:30 pm TO: Sun 6/21/09 1:00 am**

**LOCATION: Camp Williams, Azusa, Ca 91702**

I am ABLE / UNABLE to participate for the ENTIRE EVENT / FOLLOWING DAYS: \_\_\_\_\_

I request that my son, \_\_\_\_\_, be permitted to go with Troop 671 on a outing/trip to Gold Camp @ Camp Williams on 6/19/09 thru 6/22/09. He is in good physical condition. Should any illness or accident resulting in injury occur to him the outing/trip, **I WILL NOT** hold liable the Boy Scouts of America, the Orange County Council or Troop 671, it's officers or leaders, for medical aid rendered and will reimburse the Orange County Council, BSA or Troop 671 for all medical or other expenses incurred in behalf of my son.

My son may receive necessary first aid. He may receive medical attention by a duly licensed physician or other authorized emergency medical technician. He may be admitted to a hospital in case of an emergency. This authorization is given in pursuant to section 25.8 of the civil code of the state of California and remains effective only for the events and dates listed above. In the event of an emergency every effort will be made to contact the parents or legal guardian.

SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ Tel# \_\_\_\_\_ Relationship \_\_\_\_\_

## MEDICAL / HOSPITALIZATION INSURANCE INFORMATION

List of Medicines and attached directions for use: \_\_\_\_\_

List of Medicines my son is allergic to: \_\_\_\_\_

List of items my son is allergic to (bee stings, cats, dogs, hayfever, any foods, rashes): \_\_\_\_\_

Special instructions, conditions, etc: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Group No: \_\_\_\_\_ Name of Insured: \_\_\_\_\_

Insured Employer Info: \_\_\_\_\_ Tel. No: \_\_\_\_\_

My Son Physicians Name: \_\_\_\_\_ Phone: \_\_\_\_\_