

# TROOP 671 PARENT / GUARDIAN PERMISSION SLIP

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

**EVENT: Klondike Derby 2006**

**DATES: From Fri, Jan 20, 2006 TO Sun, Jan 22, 2006**

**COST: \$40.00**

**TURNED IN BY: 01/16 / 06**

**LOCATION: Camp Emerson  
53155 Idyllbrook Drive  
Idyllwild, CA 92549  
(909) 659-2690**

**MEET AT: Saint Hedwig ON: Fri 1/20/06 AT: 5:30 PM**

**RETURN TO: Saint Hedwig ON: Sun. 1/22/06 AT ABOUT: 2:00 - 3:30 PM**

**SCOUTMASTER / ADULT LEADER: Mr. Greg Shoop (Scout Master)**

**EMERGENCY CONTACT: Denise Zasadny Phone: (562) 596-8288**

PLEASE RETAIN TOP FOR YOUR RECORDS

MY SON \_\_\_\_\_ SSN: \_\_\_\_\_

**FROM: Fri. 1/20/06 5:30 pm TO: Sun 1/22/06 2:00-3:30 pm**

**LOCATION: Camp Emerson, Idyllwild**

I am ABLE / UNABLE to drive TO / FROM the event. My vehicle can transport \_\_\_\_\_ scouts/ scouters including myself. I certify that I have the required (BSA) amount of auto insurance, my vehicle is in good operating order and that all passengers will have seat belts. I also confirm that I have read and will obey the (BSA) auto safety requirements.

VEHICLE MAKE: \_\_\_\_\_ car / wagon / truck / van TAG No. \_\_\_\_\_

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

In case of an emergency, I understand that every effort will be made to contact me. In the event that I cannot be reached, I hereby give my permission to the physician selected by the adult leader in charge to secure the proper treatment which may include emergency treatment, hospitalization, anesthesia, surgery or injections of medication to my son.

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)

Name of Insurance Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group No: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ SSN: \_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_