

TROOP 671 PARENT / GUARDIAN PERMISSION SLIP

troop671.ocbsa.org on the Internet

EVENT: Red Rock Canyon SP

DATES: from **Friday April 8, 2005** till **Sunday April 10, 2005** **COST: \$30 per scout**

TURNED IN BY: 4 / 04 / 05

LOCATION: Red Rock State Park (Fri & Sat Nights)
Hwy 14, Cantil, CA

Closest Hospital: Lancaster Community Hospital
43830 10th St W
Lancaster, CA (661) 948-4781

MEET AT: Saint Hedwig ON: Fri. 4/08/05 AT: 6:00 PM

RETURN TO: Saint Hedwig ON: Sun. 4/10/05 AT ABOUT: 1:00 PM

SCOUTMASTER / ADULT LEADER: Mr. Greg Shoop & Mr. Phil Zasadny

EMERGENCY CONTACT: Mrs. Denise Zasadny Phone: 562-596-8288

PLEASE RETAIN TOP FOR YOUR RECORDS

MY SON _____ SSN: _____

FROM: Fri. 4/08/05 6:00 pm TO: Sun 4/10/05 1:00 PM

LOCATION: Red Rock State Park, Cantil CA

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:** _____

