

TROOP 671 PARENT / GUARDIAN PERMISSION SLIP

troop671.ocbsa.org on the Internet

EVENT: Catalina Backpacking Trip, May 2008
DATES: from Saturday May 24, 2008 to Monday May 26, 2008

COST: \$100.00
TURNED IN BY: 5/12/08

LOCATION: Catalina Island
No Telephone

CLOSEST HOSPITAL:

Avalon Municipal Hospital
Avalon
Phone (310)510-0700

MEET AT: St. Hedwig Parking Lot **ON:** Sat. 5/24/08 **AT:** 6:45 AM
RETURN TO: St. Hedwig Parking Lot **on:** Mon. 5/26/08 **About:** 4:00 PM (Check Boat Schedule)

SCOUTMASTER / ADULT LEADER: Mr. Phil Zasadny, Mr. Don Kovell
EMERGENCY CONTACT: Mrs. Denise Zasadny Phone: 562-596-8288

PLEASE RETAIN TOP FOR YOUR RECORDS

MY SON _____

FROM: Sat. 5/24/08 6:45 am **TO:** Mon 5/26/08 4:00 pm

LOCATION: Catalina Island

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 Catalina Memorial Day Backpack Trip on 5/24/08 thru 5/26/08. 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:** _____