

TROOP 671 PARENT / GUARDIAN PERMISSION SLIP

troop671.ocbsa.org on the Internet

EVENT: **Catalina Backpacking Trip, May 2005**

DATES: from **Saturday May 28, 2005** to **Monday May 30, 2005** COST: **\$100. food incl.**

PAID BY: 5/9/05

LOCATION: **Catalina Island**

CLOSEST HOSPITAL: **Avalon Municipal Hospital**

Avalon

No Telephone

Phone 310-510-0700

MEET AT: **St. Hedwig Parking Lot ON: Sat. 5/28/05 AT: 5:15 AM**

RETURN TO: **St. Hedwig Parking Lot ON: Mon. 5/30/05 About: 8:00 PM (Check Boat Schedule)**

SCOUTMASTER / ADULT LEADER: **Mr. Rick Lovdahl & Mr. Phil Zasadny**

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

PLEASE RETAIN TOP FOR YOUR RECORDS

MY SON _____ SSN: _____

FROM: **Sat. 5/28/05 5:15 am** TO: **Mon 5/30/05 8:00 pm** LOCATION: **Catalina**

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/OCC) 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/OCC) 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: _____
