

TROOP 671 - PARENT / GUARDIAN PERMISSION SLIP

<http://troop671.ocbsa.org> on the Internet

EVENT: **Campout at Crystal Cove** **June 25-27, 2004**
DATES: from **Friday June 25, 2004** to **Sunday June 27, 2004** COST: \$ 25.00 per scout

LOCATION: **Crystal Cove State Park** CLOSEST HOSPITAL: **Hoag Memorial Hospital Presbyterian**
8471 PCH One Hoag Drive
Laguna Beach CA Newport Beach, CA
Ph: (949) 494-3539 Ph: (949) 645-8600

SCOUTMASTER / ADULT LEADER: **Mr. Rick Lovdahl**
EMERGENCY CONTACT: **Annemarie Lovdahl (562) 795-5000**

PLEASE RETAIN TOP FOR YOUR RECORDS

MY SON _____ SSN: _____ - _____ - _____

FROM: **Fri. 6/25/04** TO: **Sun 6/27/04** LOCATION: **Crystal Cove State Park**

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/BAC) 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. _____

PARENTS:

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 INFO: (Relative, Trusted Friend) IMPORTANT in case we cannot reach you!

Name: _____ Relation: _____ Phone No. _____

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: _____

