

# TROOP 671 PARENT / GUARDIAN PERMISSION SLIP

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

**EVENT: Eagle Service Project-Mark Orland For: Tree Survey & Planting for City of Los Alamitos**

**DATES: Saturday, July 8, 2006 & Sunday July 9, 2006 (if necessary)**

**LOCATION: Little Cotton Wood Park**  
4000 Farquhar Ave  
Los Alamitos, Ca

**Rolls and Juice Provided at 8:00 am and Lunch Provided at 12 noon**

**MEET AT: Little Cotton Wood Park**      **ON: Saturday AT: 8:00 AM to: 4:00 PM**  
**Sunday AT: 8:00 AM to: 4:00 PM (if necessary)**

**SCOUTMASTER / ADULT LEADER: Greg Shoop & Mike Orland**  
**EMERGENCY CONTACT: Phone: 562-310-5122**

PLEASE RETAIN TOP FOR YOUR RECORDS

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

**FROM: Sat 7/8/06 8:00 am TO: Sun 7/9/06 4:00 pm**

**LOCATION: Little Cotton Wood 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) 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, hay fever, any foods, rashes)

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

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

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

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

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