TROOP 671 PARENT / GUARDIAN PERMISSION SLIP

troop671.net on the Internet

EVENT: Backpacking Overnight
Chantry Flat to Spruce Grove Campground
DATES: from **Saturday, September 22, - Sunday, September 23, 2007**

LOCATION: Big Santa Anita Canyon – Chantry Flat
(Entrance Gate)
1835 N. Santa Anita Ave.
Arcadia, CA 91006 (626) 821-6764 (Clear Creek Ranger Station)

COST: $15
TURNED IN BY: 9/17/2007

CLOSEST HOSPITAL:
Methodist Hospital
300 W. Huntington Dr.
Arcadia, CA 91007
(626) 898-8000

MEET AT: Saint Hedwig ON: Sat. 9/22/07 AT: 6:30 AM (Parking Lot at Chantry Flat fills up fast)

RETURN TO: Saint Hedwig ON: Sun. 9/23/07 AT ABOUT: Noon (best guess – we will call)
SCOUTMASTER / ADULT LEADER: **Greg Shoop / Steve Camferdam**
EMERGENCY CONTACT: **Mary Ellen Kane: 562-430-1309 or 714-264-1756**

PLEASE RETAIN TOP FOR YOUR RECORDS

MY SON _____

FROM: Sat. 9/22/07 6:30 am TO: Sun. 9/23/07 Noon
LOCATION: Big Santa Anita Canyon - Chantry Flat – Spruce Grove Trail Campground
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 an outing/trip to **Chantry Flat Backpacking Overnight** on 9/22/07 thru 9/23/07. 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, hay fever, any foods, rashes): _____

_____

Special instructions, conditions, etc: _____

Name of Insurance Company: _____Policy Number: _____

Group No: _____Name of Insured: _____

Insured Employer Info: _____Phone: _____

My Son Physicians Name: _____Phone: _____