TROOP 671 PARENT / GUARDIAN PERMISSION SLIP

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

EVENT: **Family Campout at Joshua Tree National Park** **Nov 12-14, 2004**
DATES: from **Friday Nov 12, 2004** to **Sunday Nov 14, 2004**

LOCATION: **Joshua Tree NP** **CLOSEST HOSPITAL:**

Families Provide their own transportation, meals & camping equipment.
Scouts will prepare meals in patrols for Sat dinner, dessert & Sun breakfast

SCOUTMASTER / ADULT LEADER: **Mr. Rick Lovdahl / Mr. Phil Zasadny**
EMERGENCY CONTACT: **N/A (since families are attending)**

PLEASE RETAIN TOP FOR YOUR RECORDS

MY SON _____ SSN: _____-_____-_____

FROM: **Fri. 11/12/04** TO: **Sun 11/14/04** LOCATION: **Joshua Tree NP**

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. _____

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 mediation 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: _____

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