

TROOP 671 PARENT / GUARDIAN PERMISSION SLIP

troop671.net

EVENT: Zac Armour's Eagle Leadership Project

DATE: Beginning Saturday, November 22, 2008 and
continuing through March 31, 2009 (dates and times will vary)

LOCATION: Bolsa Chica Wetlands - Conservancy Office

3842 Warner Ave. (PCH and Warner)
Huntington Beach 92469
(714) 846-1114

NEAREST HOSPITAL:

Los Alamitos Medical Center
3751 Katella Ave.
Los Alamitos, CA 90720
(562) 598-1311

MEET AT: _____ DATE / TIME: _____ (varies depending on date)

ADULT LEADER / ASSISTANT ADULT LEADER: **Darleen Armour** / _____ (varies depending on date)

EMERGENCY CONTACT: **Darleen Armour: (714) 308-8738**

PLEASE RETAIN TOP FOR YOUR RECORDS. SIGN AND RETURN THE FORM BELOW

PARENT / GUARDIAN PERMISSION FORM

I request that my son, _____, be permitted to participate with Troop 671 in **Zac Armour's Eagle Leadership Project at the Bolsa Chica Wetlands** on _____. He is in good physical condition. Should any illness or accident resulting in injury occur to him ON the outing/trip, **I WILL NOT** hold liable the Boy Scouts of America, the Orange County Council or Troop 671, its 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.

I am ABLE / UNABLE to participate for the ENTIRE EVENT / FOLLOWING DAY(S) _____.

SIGNATURE: _____ Date: ____ / ____ / ____

EMERGENCY CONTACT: _____ Phone #: _____ Relationship: _____

ALTERNATE Name: _____ HOME/CELL _____ HOME/CELL _____

PHONE #s

Name: _____ HOME/CELL _____ HOME/CELL _____

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): _____

Special instructions, conditions, etc: _____

Name of Insurance Company: _____ Policy Number: _____

Group No: _____ Name of Insured: _____

Insured Employer Info: _____ Phone: _____

My Son Physicians Name: _____ Phone: _____