

# TROOP 671 PARENT / GUARDIAN PERMISSION SLIP

[troop671.net](http://troop671.net)

Cost: \$559  
Turned in By: 6/15/2009

**EVENT: Summer Camp - Camp Emerald Bay**  
**DATE:** Sunday, July 12, 2009 - Saturday, July 18, 2009

**LOCATION: BSA Camp Emerald Bay**  
P.O. Box 5066  
Avalon, CA 90704-5066  
(310) 510-1795

**NEAREST HOSPITAL:**  
**Catalina Island Medical Center**  
100 Falls Canyon Road  
Avalon, CA 90704  
(310) 510-0700

**LEAVING FROM: Catalina Express San Pedro Terminal: Sun, 7/12/2009 at 1:00 PM**  
Be at terminal at least one hour before departure (noon).

**ARRIVING TO: Catalina Express San Pedro Terminal: Sat, 7/18/2009 at 2:00 PM**

SCOUTMASTER / ADULT LEADER: **Greg Shoop / Mike Getscher**  
EMERGENCY CONTACT: **Mary Ellen Kane: (562) 430-1309 or (714) 264-1756**

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

## PARENT / GUARDIAN PERMISSION FORM

I request that my son, \_\_\_\_\_, be permitted to go with Troop 671 on an outing/trip to **Summer Camp - Camp Emerald Bay on Sunday, July 12, 2009 - Saturday, July 18, 2009**. 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: \_\_\_\_\_