BOY SCOUTS OF AMERICA **VENTURA COUNTY COUNCIL**

PARENT OR GUARDIAN CONSENT AND APPROVAL FOR

TROOP 718 ACTIVITY

(Applies to all personnel under the age of 18)

TO WHOM IT MAY CONCERN:

SCOUT: _____

ADDRESS _____

DATE OF BIRTH: __/ ___/ _____ PHONE: (___)_____CELL (____)_____
Month Day Year

has my/our permission to participate in Troop 718 BSA Troop Outings and Activities at various outings, activities and events.
I/We approve of the leaders who will be in charge of this activity [parents and leaders of Boy Scout Troop 718].
I/We also certify that to the best of my/our knowledge the Scout named hereon is physically fit to engage in the activity described above.

DATE: _____ SIGNED: _____ RELATIONSHIP: _____
(Both parents and/or all guardians are requested to sign)

DATE: _____ SIGNED: _____ RELATIONSHIP: _____
(Both parents and/or all guardians are requested to sign)

Print Name(s): _____

AUTHORIZATION AND CONSENT TO TREAT A MINOR

Pursuant to California Civil Code Section 25.8

The undersigned does hereby authorize: **ALL SCOUT LEADERS**
or such substitute as he/she may designate as agent for the undersigned to consent to any x-ray, examination, anesthetic, medical or surgical diagnosis or treatment and hospital care for the above minor which is deemed advisable by and to be rendered under the general or special supervision of any physician and surgeon, licensed under the provision of medicine practice act or any dentist licensed under the dental practice act, whether such diagnosis or treatment is rendered at the office of said physician or dentist, at a hospital, scout camp or elsewhere.

This authorization will remain effective while the above minor is enroute to or from or involved or participating in the above noted activity.

DATE: _____ SIGNED: _____
(Both parents and/or all guardians are requested to sign)

IN CASE OF EMERGENCY PLEASE NOTIFY:

NAME: _____ PHONE: _____
(print)

ALT. NAME: _____ PHONE: _____
(print)

PHYSICIAN: _____ PHONE: _____
(print)

SPECIAL MEDICAL CONDITIONS:_____
continue on back as needed

MEDICATIONS TAKEN AND DOSAGES:_____
Continue on back as needed

ALLERGIES_____
Continue on back as needed

Med. Ins Provider: _____ Member #: _____

Policy Number: _____ PHONE_____