

WEBELO PIN COLLEGE

PARENT OR GUARDIAN CONSENT, RELEASE AND APPROVAL FOR ACTIVITY

TO WHOM IT MAY CONCERN:

CHILD (print name): \_\_\_\_\_

ADDRESS: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_  
MONTH / DAY / YEAR

has my permission to participate in: Troop 718 BSA /Webelos Pin College to be held: throughout October 11, 2014 at: Westminster Presbyterian Church 8 am – 4:00 p.m.

I approve of the adults who will be in charge of this activity [parents and leaders of Boy Scout Troop 718]. I also certify that to the best of my knowledge the child named hereon is physically fit to engage in the activities described above.

DATE: \_\_\_\_\_ SIGNED: \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
(Parent or Guardian)

(Print name:) \_\_\_\_\_  
(Parent or Guardian)

AUTHORIZATION AND CONSENT TO TREAT A MINOR AND RELEASE OF LIABILITY  
Pursuant to California Civil Code Section 25.8

The undersigned does hereby authorize: Scoutmaster Jeff Long, Troop 718 adult leaders, or such substitute as he 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, medical facility, or elsewhere.

This authorization will remain effective while the above minor is on route to or from or involved or participating in any program or activity as mentioned above, unless revoked in writing by the undersigned and delivered to the aforesaid agent.

DATE: \_\_\_\_\_ SIGNED: \_\_\_\_\_  
(Parent or Guardian)

IN CASE OF EMERGENCY PLEASE NOTIFY:

NAME (print): \_\_\_\_\_

PHONE:(\_\_\_\_)\_\_\_\_\_ Must be available during event

PHYSICIAN (print): \_\_\_\_\_

PHONE:(\_\_\_\_)\_\_\_\_\_

SPECIAL MEDICAL CONDITIONS: \_\_\_\_\_

\_\_\_\_\_

MEDICATIONS TAKEN AND DOSDAGES: \_\_\_\_\_

\_\_\_\_\_

ALLERGIES: \_\_\_\_\_

\_\_\_\_\_

**\*SPECIAL FOOD NEEDS:** please send a sack lunch to accomodate your child's needs.

Med. Insurance Provider: \_\_\_\_\_

Member or Policy # \_\_\_\_\_