



Long Beach Area Council Boy Scouts of America

401 East 37th St., Long Beach, CA 90807

PO Box 7338

Telephone: 562-427-0911

PARENT RELEASE FORM

I hereby make application for Scout: _____ of B.S.A. Troop #224 for a place in the camp, trip, or cruise, as described below. Said member is to be amenable to such rules and regulations as may be made by the Executive Board or its representatives.

It is expressly understood by the parents or guardian that the member for whom this application is made is in a condition of health that warrants his taking part in this event, and that the leader of this outing is hereby granted permission to take the named member to a medical doctor for examination and treatment of any accident or illness that may arise during the term of said outing. (See authorization below.)

AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR

(I) (We), the undersigned parent (s) of _____ a minor, do hereby authorize the Scoutmaster or his authorized representative as agent(s) for the undersigned to consent to any X-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision, of any physician or surgeon licensed under the provision of the Medicine Practice Act on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care which the aforementioned physician, in the exercise of his best judgment may deem advisable. This authorization shall remain effective for the date of the event given below.

PLACE/EVENT: _____

DATES: From _____ To _____

MEETING TIME & PLACE: _____

RETURN TIME & PLACE: _____

MODE OF TRANSPORTATION: Troop vans, trucks and cars

PHONE NUMBERS WHERE PARENT MAY BE CONTACTED:

Parent/Guardian: _____ Home: _____ Cell/Work: _____

Emergency Contact*: _____ Phone: _____ Relationship: _____

**In case parent cannot be contacted.*

ALLERGIES OR ALLERGIC REACTIONS: _____

PRIVATE INSURANCE CARRIER: _____

POLICY #: _____

CARRIER PHONE NUMBER: _____

SPECIAL MEDICATIONS: _____

Additional medical information must be detailed on the back of this form.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____