

Troop 209 Permission Slip

Activity \_\_\_\_\_  
Troop 209 is leaving \_\_\_\_\_ 20 \_\_\_\_\_. We will return on \_\_\_\_\_ 20 \_\_\_\_\_. We  
will leave at \_\_\_\_\_ from \_\_\_\_\_ We will return at approximately  
at \_\_\_\_\_ at \_\_\_\_\_. Remember the return time is an  
approximation as there may be matters beyond the control of the drivers and/or leaders.  
If you need to contact your Scout(only in case of an emergency call: \_\_\_\_\_  
at \_\_\_\_\_. Be aware it may be difficult to contact us.  
(Please remove and retain this part)

Waiver of Responsibility

(Trip leader to collect from each Scout)

Troop 209 Boy Scouts of America, sponsored by the Knights of Columbus #8077. In consideration of the benefits derived, and in the view of the fact that the BSA is an educational institution, membership in which is voluntary, and having full confidence that every precaution will be taken to ensure the safety and well being of my Scout, namely \_\_\_\_\_ On the activity named, I agree to his participation and waive all claims against the leaders of this trip, officers, agents, and representatives of the Boy Scouts of America, and the Sponsoring Organizations.

In the event of an emergency, the Troop unit leader of the activity listed has my permission to obtain medical treatment at the nearest hospital or doctor, at my expense. If our own doctor is not readily available, and as restricted on the Emergency Data Sheet on file with Troop 209 AND ANY EXCEPTION OR DIRECTIONS LISTED BELOW.

Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_

Activity \_\_\_\_\_

Emergency Information \_\_\_\_\_

During the activity listed, I will be available at the following numbers \_\_\_\_\_

This Scout is highly allergic or sensitive to \_\_\_\_\_

What if any medications is this Scout taking? \_\_\_\_\_

Any Special instructions for this medication? \_\_\_\_\_

Will the unit leader carry for the medication? Yes \_\_\_\_\_ No \_\_\_\_\_

Date of last Tetanus shot/booster \_\_\_\_\_

Medical Insurance Info: Company: \_\_\_\_\_ HMO/PPO \_\_\_\_\_

Policy numbers \_\_\_\_\_

Emergency Contact: Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_