

# Boy Scout Troop 806

ARROHATTOC DISTRICT, HEART OF VIRGINIA COUNCIL OF THE BSA  
WOODLAKE UNITED METHODIST CHURCH, SPONSOR  
JEFF DEHOFF, SCOUTMASTER

## PERMISSION SLIP AND/OR WAIVER OF RESPONSIBILITY

Activity: **T806 Scout Skills Campout**

Location: **Finley Albright Scout Reservation  
Chesterfield, VA**

Departure Date: **June 12, 2010**

Return Date: **June 13, 2010**

Activity Leader: **Jeff Lee**

### PLEASE FILL OUT FORM IN FULL

NAME OF SCOUT CAMPER: \_\_\_\_\_

Name(s) of Adult Camper(s): \_\_\_\_\_ Phone(s) (home & cell): \_\_\_\_\_

Name(s) of Additional Family members Camping: \_\_\_\_\_

**TROOP SUPPORT:** Can parent help to transport to site? No  Yes ..... from site? No  Yes

Vehicle (year/make): \_\_\_\_\_ Ins. Co.: \_\_\_\_\_ # Boys you can carry: \_\_\_\_\_ (NOTE: A seat belt per boy is required!)

Liability Insurance Coverage: Each person \$ \_\_\_\_\_ Each accident: \$ \_\_\_\_\_ Property Damage: \$ \_\_\_\_\_

**PARTICIPATION WAIVER** for my son/ward, namely: \_\_\_\_\_ from the \_\_\_\_\_ Patrol. In consideration of the benefits to be derived, and since the Boy Scouts of America 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 son/ward, named above on the activity identified above, 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 Sponsor, Woodlake United Methodist Church and its associations. Upon an emergency, illness, or accident during the activity identified above, I understand every effort will be made to contact me. In the event that I cannot be reached in a timely manner and our own doctor is not readily available, the troop or unit leader of the activity identified above has my permission to obtain without delay medical treatment as judgment of medical personnel dictates. Proper medical treatment may include hospitalization, anesthesia, surgery, or injections of medication for my son/ward.

Signature of Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Signature of Parent or Guardian: \_\_\_\_\_

### **EMERGENCY INFORMATION:** (Required update for troop Health and Medical Records).

During the activity identified above, We/ I can be contacted at the following phone/ locations:

(\_\_\_\_) \_\_\_\_\_ / \_\_\_\_\_ or (\_\_\_\_) \_\_\_\_\_ / \_\_\_\_\_. If we/ I can not be reached,  
phone / location phone / location

Contact: (name) \_\_\_\_\_ / (\_\_\_\_) \_\_\_\_\_ (relationship to boy) \_\_\_\_\_

Scout's physician \_\_\_\_\_ Phone: \_\_\_\_\_

Scout's Allergies: \_\_\_\_\_

**MEDICATION: IF ANY SCOUT NEEDS TO TAKE MEDICATION OF ANY KIND DURING THE CAMPOUT, THE MEDICATION MUST BE HAND-DELIVERED BY THE PARENT TO THE MEDICINE (WO)MAN BEFORE LEAVING WUMC. ALL MEDICATION MUST BE IN A ZIPLOCK BAG, CLEARLY LABELED WITH ADMINISTERING INSTRUCTIONS—NO EXCEPTIONS!!**

Scout's currently prescribed medication: \_\_\_\_\_

MEDICINE WOMAN: Holly McKay Date of last tetanus shot or booster: \_\_\_\_\_

Family Medical Insurance: Company: \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

To be completed by troop scribe

FEES PAID: Adult food \_\_\_\_\_ Adult camp fee \_\_\_\_\_ Scout food \_\_\_\_\_ Scout Camp fee \_\_\_\_\_

Received by \_\_\_\_\_ Date: \_\_\_\_\_

**Prescription Medication Information Form**

SCOUT NAME: \_\_\_\_\_ DATE TO BE GIVEN: \_\_\_\_\_

MEDICATION: \_\_\_\_\_ DOSAGE \_\_\_\_\_

**Specific Instruction for dispensing medication:** \_\_\_\_\_

PARENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PHONE NO. WHERE I CAN BE REACHED: \_\_\_\_\_

A SEPARATE FORM MUST BE FILLED OUT FOR EACH MEDICATION

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