TROOP 161
Bethesda Presbyterian Church

Parents Scout Activity Information

Scout Troop 161 will participating in a __**Troop Campout**__ on the following dates:

(date) _____ through _____

Our troop will be leaving from:__Bethesda Presbyterian Church_ at (time) _____ and traveling

to(destination)_____

_____

We will be returning to _____ on (date) _____ at approximately (time) _____.

Phone Number where the Troop can be reached: _____

Cell Phone Number(s) of drivers and Scout leaders

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

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Troop 161
Consent For Medical Treatment

In the event that my child becomes ill or injured while under Troop/Pack Leader's supervision, I approve of the Troop/Pack Leaders taking the following steps:

1. Contact a parent or legal guardian of the youth and follow his/her instructions.
2. In the event of an emergency when neither parent nor legal guardian can be reached immediately, the Bethesda Youth Leadership is hereby authorized to use their best judgment in contacting a properly licensed physician or in transporting my child to the nearest hospital for consultation and /or treatment. Troop/Pack Leaders will provide transportation or if the Troop/Pack Leaders deem it necessary, by ambulance.

If in the opinion of a licensed and practicing physician, my child needs medical or surgical services, which require my consent before being supplied, and I cannot be reached, I authorize, appoint, and empower the Troop/Pack Leadership to furnish on my behalf such written or oral authorization as may be so required.

Furthermore, I release Bethesda Presbyterian Church, any of its youth leaders from any liability that might arise from the giving of such authorization; it being my desire that my child be furnished such medical or surgical services as soon as possible after the need arises. I agree to be responsible for all medical services that result from the above treatment without my consent.

List any Medications your child is taking or may require.

_____

List any allergies or allergic reactions to medication your child may experience.

_____
_____

My insurance company is _____
Policy Number: _____

Signature of Parent/Guardian: _____Date: _____

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