TROOP 9

Boy Scouts of America
South Weymouth, Massachusetts

ACTIVITY PERMISSION SLIP

As the Parent/Guardian of _____ I give my permission for him to go with Troop 9

to:_____, departing on _____, 20___
(name of activity) (date)
and returning on _____, 20___
(date)

The following is a list of any medical issues, physical problems or limitations that the adult leaders should be aware of during my child's participation in this activity?

_____

The following is a list of any known allergies my child may have and his reaction to them.

_____

Is regular or emergency medication required during this trip? **_____Yes _____No** If so please list.

_____
(Name of medication) (Dosage) (When taken)
_____
(Name of medication) (Dosage) (When taken)
_____
(Name of medication) (Dosage) (When taken)

I give permission to the troop leaders to hold and administer the medications listed above. **_____Yes ____No**

I give my son permission to hold and administer his medications. **_____Yes ____No**

By checking the box(s) below, I give permission for the following non-prescription medications/ointments to be administered by the troop leadership as may be necessary for the comfort of my child:

☐ Tylenol ☐ Ibuprofen ☐ Anti-bacterial Ointment ☐ Sunburn Ointment ☐ Hydrogen Peroxide ☐ Antacid

☐ Sting-Eze ☐ Other (please describe) _____

(Please note that ointments <u>will not</u> be applied by adults)

In case of emergency, please notify:

Parent/Guardian Contact: _____ Relationship:_____
Home #: _____ Work #: _____ Cell #: _____
Alternate Contact: _____ Relationship: _____
Home #: _____ Work #: _____ Cell #: _____

In case of emergency, I understand every effort will be made to contact me (if an adult, my spouse or next of kin). In the event I cannot be reached, I hereby give my permission to the physician selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medicine for my child (or for me, if an adult).

Signature of Parent or Guardian _____ Date: _____

Health Insurance Provider: _____ Policy # _____