

# TROOP 76 - BOY SCOUTS OF AMERICA

Jesse Lee Memorial UMC, Ridgefield, Connecticut  
Participation Consent Form



Trip: \_\_\_\_\_  
 Meet at: Jesse Lee Back Parking Lot Time: \_\_\_\_\_ Date: \_\_\_\_\_  
 Pickup: Jesse Lee Back Parking Lot Time: \_\_\_\_\_ Date: \_\_\_\_\_

**\*\* NOTE: If you do not pick up your son within 30 minutes of this time, we may transport him to the Ridgefield Police Station; you may pick him up there.**

In case of Emergency during the trip, contact Troop through:

\_\_\_\_\_  
 \_\_\_\_\_

**Dear Parent:** This form is necessary and required for each and all troop activities. No individual will be allowed to go this trip unless this form is signed and turned in prior to the trip. We will do everything reasonably within our power to protect each participant. It is our intent to provide adequate supervision by the adult scouters and parents of the troop members who will be on this trip.

\* \* \* \* \* C U T T O P A N D S A V E \* \* \* \* \*

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## TROOP 76 BOY SCOUTS OF AMERICA PARTICIPATION CONSENT FORM

Trip: \_\_\_\_\_  
 Date: \_\_\_\_\_

*In consideration of the benefits to be derived, and in view of the fact that the Boy Scouts of America is an educational, nonprofit institution, membership and participation in which is voluntary, and having full confidence that every reasonable precaution will be taken to ensure the safety of the participant named below on this activity, I hereby agree to his participation and waive all claims against the leaders of this trip, officers, agents, and representatives of the Boy Scouts of America, this Troop, and the sponsor.*

Participant Name: \_\_\_\_\_  
 Any condition now requiring medication?  No  Yes  
 Name of medication & dosage: \_\_\_\_\_  
 Any restriction of activity for medical reasons?  No  Yes  
 If Yes, explain in detail: \_\_\_\_\_  
 Special medical instructions (e.g. drug or food allergies): \_\_\_\_\_

*In the event I cannot be reached in an emergency, or if an attending physician or health care provider believes immediate medical care is required without delay, I hereby give permission to the physician or health care provider, selected by the adult leader, to secure medical treatment, hospitalize, secure anesthesia, or to order injection or surgery for the participant named above, at my expense.*

Signature of Parent or Guardian: ✍ \_\_\_\_\_ Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Health Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_  
 Family Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

**[Note: Scouts should contact their patrol leader regarding specific times and dates]**