ACTIVITY PERMISSION SLIP AND/OR WAIVER OF RESPONSIBILITY TROOP 510

Activity Name: _____		Scout/Youth's Name: _____	
Activity Location: _____		Scoutmaster in Charge: _____	
Depart Date: _____	Depart Time: _____am/pm	Depart Location: _____	
Return Date: _____	Return Time: _____am/pm	Return Location: _____	
Scout's Food Fee: $_____	Paid on: _____/_____/_____	Scout's Camp Fee: $_____	Paid on: _____/_____/_____

TROOP SUPPORT: (*Activity Permission Slip Addendum May Be Substituted for this section)

I can help transport Scouts to and/or from this activity: ***TO***: Yes No ***FROM***: Yes No

Fill out the following section if you are planning on transporting Scouts (including your own youth) to or from the event and you have not updated your insurance information within the last year or your insurance information has changed.

# Seat belts: _____			*Public Liability Coverage*		
Vehicle: _____ _____/_____		Ins. Co. _____	Coverage:_____ / _____ / _____	DL: ___ _____	
year	make / model	*name*	*Per Person/Per Accident/Prop. Dmg Minimum: 50,000 / 100,000 / 50,000*	*state*	*number*

PARTICIPATION WAIVER for the youth listed above. 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 son/daughter on this activity, I agree to their participation and waive all claims against the leaders of Troop 270, parent volunteers, officers, agents, and representatives of the BSA, the sponsor, St James United Methodist Church and any and all associations. I further understand that my son/daughter will be transported in a privately owned vehicle that has met the standards set in place by the BSA.

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, the troop or unit leader in charge of the activity 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/daughter.

I also give permission for my son's/daughter's name and/or photograph to be used in the Troop's website and/or newsletter, in accordance with the Troop's current privacy/website policy. Furthermore, I understand that photographs may also be used in local, regional and/or national newspaper articles that may or may not use my son or daughter's last name.

Signature of Parent/Guardian: _____ Date: _____/_____/_____

Printed Name of Parent/Guardian: _____

EMERGENCY INFORMATION:

(Required update for Troop Health and Medical records – complete before each activity.)

During this activity, I/we can be contacted at the following numbers: (____) ____-_____ or (____) ____-_____. If I cannot be reached by phone, contact _____ at ____-____-_____. Relationship to youth: _____

My son/daughter's physician is: _____ Phone: (____) ____-_____

Known allergies are: _____

Medications: _____

(All medications must be in their original containers with Scout name, medication name and dosage instructions on it.)

Do you want the Scoutmaster in Charge to carry this medication: Yes No *(Write special instructions on back of this paper.)*

Date of last tetanus shot or booster: _____/_____/_____.