



DIOCESE OF HARRISBURG—DIOCESAN CATHOLIC COMMITTEE ON SCOUTING

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MEDICAL PERMISSION FORM

Scout's Name: _____ Pack/Troop #: _____

Address: _____

(City) _____ (State) _____ (Zip Code) _____

While attending, or traveling to and from, meetings or special activities, I hereby authorize the leader of said troop, or in his absence or disability, any adult accompanying or assisting him, to consent to any x-ray examination, anesthetic, dental or surgical diagnosis or treatment and hospital care at a licensed hospital which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and/or surgeon licensed to practice medicine or to consent to an x-ray examination, anesthetic, dental or surgical diagnosis or treatment and hospital care to be rendered to said minor by a dentist licensed to practice dentistry.

Signed: _____

Relationship to participant: _____

Do you have hospitalization insurance? Yes No

Policy Number: _____

List any medications you are taking: _____

Emergency Contact

Name: _____

Address: _____

(City) _____ (State) _____ (Zip Code) _____

Home Phone #: _____ Work Phone #: _____

or
Name: _____

Address: _____

(City) _____ (State) _____ (Zip Code) _____

Home Phone #: _____ Work Phone #: _____

