DIOCESE OF HARRISBURG–DIOCESAN CATHOLIC COMMITTEE ON SCOUTING
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E-mail: oyyam@hbgdiocese.org • Web Site: www.hbgdiocese.org/youngchurch

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 #: _____

Family Physician: _____ Phone: _____

Allergic reactions (medications, foods, insects, etc.)

_____

_____

My child has special medical/mental conditions: ❑ Yes ❑ No (**if yes**, please describe)

_____

_____

_____

Parents/guardians of participants are advised that photograph or videotape of participants may be used in publications, websites or other materials produced from time to time by the Office for Youth and Young Adult Ministry or the Diocese of Harrisburg. (Participants would not be identified, however, without specific written consent.) Parents/guardians who do not wish their child(ren) to be photographed or filmed should so notify the Office in writing. Please note that the Office has no control over the use of photographs or film taken by media that may be covering the event in which your child(ren) participate(s).

_____ _____

Parent/Guardian Signature Date

File:ajpfile\DCCS\Diocese med.doc

The Harrisburg Diocese Committee on Scouting Serves the following counties within the Commonwealth of Pennsylvania: *Adams, Columbia, Cumberland, Dauphin, Franklin, Juniata, Lancaster, Lebanon, Mifflin, Montour, Northumberland, Perry, Snyder, Union and York*

Pennsylvania Dutch Council Boy Scouts of America

Medical Information/Informed Consent/Hold Harmless Agreement

Name: _____ Date_____ Date of Birth _____
Address: _____
Telephone # _____
Name of personal Physician: _____
In case of emergency contact: _____
Phone: _____ or _____
List known Allergies _____
If you are allergic to bee stings, do you have a bee sting kit? _____
Do you wear contact lenses? _____ Are you pregnant?_____
Have you had or do you have (circle if yes) Diabetes Asthma Angina Epilepsy
Chest pains Drug reactions high blood pressure heart murmur
Heart attack (if yes, date) _____
Have you ever had any serious disease or surgery? (If yes, explain and include date)
_____
Do you have any other medical conditions we should be aware of? _____
_____

I understand that participation in the C.O.P.E. / Climbing/ rappelling activity offered through the Pennsylvania Dutch Council, BSA, on (date)_____, involves a certain degree of risk that could result in injury or death. In consideration of the benefits to be derived and after carefully considering the risk involved, and in view of the fact that the Boy Scouts of America is an organization in which membership is voluntary, and having full confidence that precautions will be taken to ensure the safety and well-being of my child, I give my permission for my child to participate in the C.O.P.E. program. I herby release and hold harmless and waive any claims I may have against the Pennsylvania Dutch Council, BSA, the National Council BSA and it s chartered affiliates, agents, servants, employees, officers from all cost and expenses including but not limited to, attorney's fees, reasonable investigations and discovery costs, courts cost, and all other sums the above mentions persons may pay or become obligate to pay on account of any, all and every demand for claim or assertion of liability, or any claim or action founded thereon arising or alleged to have arisen out of your child's us of real or personal property belonging to the Pennsylvania Dutch Council, BSA or by any actions or omission by your child. In case of emergency, I understand every effort will be made to contact me. In the event I cannot be reached, I herby give my permission to the physician selected the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child.

This form must be signed by both parents/guardians

I am not under the influence of any chemical substance including alcohol. Understanding that any physical activity involves a risk of injury I understand that my participation in the Pennsylvania Dutch Council. BSA, C.O.P.E. program is entirely voluntary. I release the Pennsylvania Dutch council BSA and all its employees from any claims or liability arising out of my participation. The release does not, however, apply to any harm caused by negligence or willful misconduct of the Pennsylvania Dutch Council, BSA or its employees.

Name (print)_____Course date_____

Participant's signature: _____ Date _____
*If participant is under age 18, his or her parents or guardians must also sign below

Parent/guardian Signature)_____

Parent/guardian Signature)_____

Permission Slip

As the parent or legal guardian of _____ , I hereby give my permission for this child to participate in a outing with Troop 103.

				Location
Activity:	Diocesan Religious Retreat			Camp Bashore, Lebanon County, PA
Departure Time:	tbd	**Date:**	09/18/09	St. Joseph Church, Grandview Rd., Hanover, PA
Return Time:	noon	**Date:**	09/20/09	St. Joseph Church, Grandview Rd., Hanover, PA

I understand that participation in Scouting activities involves a certain degree of risk. I have carefully considered the risk involv and have given consent for myself or my child to participate in these activities. I understand that participation in these activities entirely voluntary and requires participants to abide by applicable rules and standards of conduct. I release the Boy Scouts of America, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with the activity from any and all claims or liability arising out of this participation.

I approve the sharing of the information on this form with BSA volunteers and professionals who need to know of medical situations that might require special consideration for the safe conducting of Scouting activities.

In case of an emergency involving me or my child, I understand that every effort will be made to contact the individual listed as the emergency contact person. In the event that this person cannot be reached, permission is hereby given to the medical provider selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for me or my child. Medical providers are authorized to disclose to the adult in charge examination findings, test results, and treatment provided for purposes of medical evaluation of the participant, follow-up and communicatio with the participant's parents or guardian, and/or determination of the participant's ability to continue in the program activities.

In case of emergency, I can be reached by phone at _____ or _____.

If I cannot be reached, please contact _____ at _____.

Signed: _____ Date: _____
(Parent or Guardian)