



SCOUTS OF HOMENETMEN ARARAT CHAPTER

PERMISSION/MEDICAL RECORD

I hereby authorize my son/daughter _____ To go on day camp/over night trip
 at _____, with Homenetmen Troop No. _____ Date from _____ to _____
 Name of Parent or Guardian _____
 Home address _____
 Telephone # Home: _____ Work _____ Cell _____
 Date of Birth _____ Age _____ Sex _____ Height _____ Weight _____
 Doctor's name: _____ Telephone # _____
 Family medical insurance carrier _____ Group # _____ ID _____

In an emergency, if unable to reach parent, contact:

Name/relationship _____ Telephone # _____
 Name/relationship _____ Telephone # _____

Check the items that apply to your child

ASTHMA { } ENVIRONMENTAL ALLERGIES { } SLEEP WALKING { } BED WETTING { }
 DIABETES { } ALLERGY TO INSECT STINGS { } HEART PROBLEM { } SEIZURE { }

Please Explain: _____
 Does your child have any other serious medical condition or been under a physicians care recently: Yes { } No { }
 If yes please explain _____

Does your child have any of the following:

Allergic to medication? _____
 Diet restrictions? _____
 Date of last tetanus shot? _____/_____/_____

MEDICATION AT CAMP

The scout may not have any medications (pill or oral liquid) in his/her possession. This includes over-the-counter medications like **TYLENOL**. All medications must be given to and be held by a Scoutmaster or the camp medic. Who will administer it according to the written Instructions. All medications should come in its original container. Please, clearly label each bottle with the scout's name and place all medicine in closed plastic bag or container.

List all the medications your child must take on a regular schedule while at Camp:

MEDICATION	DOSAGE	HOW OFTEN	WHEN

In the event of a minor illness, do you authorize the camp medic to give your child common remedies in appropriate dosages? YES { } NO { }
 EXAMPLES: NON-ASPIRIN PAIN RELIEF, COUGH MEDICINE, ANTACID

I, the undersigned parent or legal guardian of the above named, do hereby authorize and consent to any x-ray, anesthetic, surgical or medical treatment rendered by medical or emergency room staff licensed under the provisions of the Medicine Practice Act, in the State of California, Dept. of Public Health. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care deemed advisable by aforementioned physician in the exercise of the doctor's best judgement. It is understood that every effort will be made to contact the undersigned prior to rendering treatment to the patient, but none of the above treatment will be withheld if the undersigned cannot be reached. This authorization is given pursuant to the provisions of section 25.8 of the civil code of California.

SIGNATURE OF PARENT/GUARDIAN _____ DATE _____

Scout Name _____ Troop _____ Camp _____