HOMENETMEN Glendale Ararat Chapter

Mailing Address and Activity Center: www.Ararat.org E-mail: info@Ararat.org

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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:

Alergic 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 authorizartion is given in advance of any specific diagnosis, treatment or hospital care deemed advisable by aforementioned physician in the excersise 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_____