

Troop 129 - Oak Ridge, Tennessee
TRIP PERMISSION AND RELEASE
Great Smoky Mountain Council
Troop Year: October 2007 – September 2008

I, the undersigned parent/guardian of _____ hereby give written permission for him to participate in the activities and outings of Boy Scout Troop 129, Oak Ridge, Tennessee, for the year listed above.

In absence of explicit direction from me, I do delegate the Scoutmaster or other assigned adult leader as the appropriate authority to act *in loco parentis*, specifically to authorize any medical aid, including the use of medicines, drugs and surgery, as recommended by competent and legally licensed medical personnel in any situation in which it is deemed necessary.

Parent/guardian signature

Scout's Name: _____ Scout's Date of Birth: _____
Scout's home address: _____ Scout's home phone: _____

IN CASE OF EMERGENCY NOTIFY:

Father's work phone: _____ Mother's work phone: _____
Father's cell phone: _____ Mother's cell phone: _____
Doctor's Name: _____ Doctor's Phone: _____
Medical Insurance Company/Carrier: _____
Policy Holder (name): _____ Ins. Co. toll-free number: _____
Policy Number: _____ Policy Group: _____

HEALTH HISTORY

Does the Scout have or is he subject to (check if *yes*): _____ check here if none apply

<input type="checkbox"/> ADHD (Attention Deficit Hyperactive Disorder)	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Heart trouble
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hemophilia/bleeding disorders
<input type="checkbox"/> Cancer/leukemia	<input type="checkbox"/> Fainting spells	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Allergy to any medication, food, plant, animal or insect toxin	<input type="checkbox"/> Any condition that may require special care, medication or diet	

Explain: _____

Medications: _____

Have difficulty with (check if *yes*):

Eyes, ears, nose, throat Digestion Lungs Sleep-walking Bed-wetting

Any restriction of activity for medical reasons? Yes No

Explain: _____

List equipment needed (wheelchair, braces, glasses, contact lenses, etc.) _____

Immunizations (give date of last inoculation):

_____ Tetanus Toxoid	_____ Polio	_____ Mumps	_____ Pertussis
_____ Diphtheria	_____ Measles	_____ Rubella	