



Boy Scout Troop 17 Northfield, Illinois

Committee Chairman: Curtis Tate
Scoutmaster: Jon Shabica
Charter: Northfield Community Church

Trip destination & activity: _____

Permission is valid for (trip dates): _____

Scout's Name: _____

Address: _____ City, State, Zip: _____

Home Phone #: _____ Emergency Phone #: _____

Permission To Participate and Waiver of Responsibility for Troop 17 Activities

In consideration of the benefits to be derived, and in view of the fact that the Boy Scouts of America is an educational institution, membership in which is voluntary, and having full confidence that every reasonable precaution will be taken to ensure the safety and well being of my Scout son/ward (named above), I agree to his participation, and waive all claims against (a) the leaders/organizers of these activities, (b) Troop 17, (c) Troop 17's chartering organization, namely Northfield Community Church and its affiliated organizations, (d) Northeast Illinois Council, (e) the Boy Scouts of America, and (f) the officers, agents, representatives, and affiliates of the aforementioned parties.

Permission To Obtain Emergency Medical Treatment and Release Medical Information

In the event of a medical emergency, I parent/guardian of above listed Scout, do hereby appoint any adult leader of Troop 17 as my agent and representative and do hereby give permission to (a) obtain medical treatment for my Scout son/ward at the nearest medical facility at my expense, (b) disclose health/medical and insurance information I have provided in any form to providers of medical assistance, and (c) take any other measures deemed appropriate. I certify that I am the parent or legal guardian of the Scout named above, and that I have read and understand this document in its entirety. I affirm that I agree with the terms of this document without qualification.

MEDICAL INFORMATION

____ Allergy to a medicine, food, plant, animal, insect or toxin _____

____ Any medication the scout has been on within the past 12 months: Yes No

Medication Name: _____ Dosage: _____

____ Any conditions that may require special care, medication or diet _____

Limitations of physical activity: _____

MEDICAL EMERGENCY

In case of accident, injury or illness while participating in Troop activities, I hereby give my permission to the doctor selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery or injections of medications.

Signature of Parent or Guardian _____ Date: _____

Print Name: _____ Relationship: _____