



TROOP 20 ACTIVITY CONSENT FORM AND APPROVAL BY PARENTS OR LEGAL GUARDIAN

Scout's first and last name _____ Birth date ____ / ____ / ____ Age during activity _____

Address _____

Additional address (need street address if you have a PO box) _____

City _____ State _____ Zip _____

Phone number _____

Has approval to participate in _____
(Name of activity, orientation flight, outing trip, etc.)

From _____ (Date) to _____ (Date) **** See attached page for Activity details**

Additional Family Members Attending: _____

Adult family member available to drive - Name _____	
Vehicle driving _____	# seats with seatbelts including driver _____
On each Troop 20 trip, we need drivers - if you have not completed a Vehicle Insurance information form, please obtain a copy from Troop 20 leadership.	

Form & money due by _____	Cost per person _____
(No Refunds)	

Total Paid _____		
Payment type (Circle One)		
Cash	Check	Account

- Without restrictions
- Special considerations or restrictions (medical or allergies, etc.) _____

Please list medications to be taken during activity _____

HOLD HARMLESS AGREEMENT

I understand that participation in this activity involves a certain degree of risk. I have carefully considered the risk involved and have given consent for myself or my child to participate in the activity. I understand that participation in the activity is 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.

In case of emergency involving my child, I understand every effort will be made to contact me. In the event I cannot be reached, I hereby give my permission to the medical provider selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for 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 communication with the participant's parent or guardian, and/or determination of the participant's ability to continue in the program activities.

Participant's signature _____ Date _____

Parent/guardian printed name _____

Parent/guardian signature _____ Date _____

Area code and telephone number (best contact and emergency contact) _____ E-Mail (for use in sharing more details about trip or activity) _____

Contact the adult leader with any questions:

Name: _____

Phone: _____ E-mail _____