

# Boy Scout Troop 201 – Olmsted Falls

## Consent, Authorization and Release

I consent to my son, \_\_\_\_\_ participating in the activities of the Boy Scout Troop 201 from the date of this release through March 31<sup>st</sup>, 2010, or until this consent is revoked in writing.

I authorize the Troop 201 adult leaders to seek, select and implement emergency medical, dental, surgical and hospital treatment for my son, and further authorize any licensed physician or dentist to treat him as the physician or dentist deems necessary.

I release Troop 201 adult leaders from any liability arising from such selection and implementation of emergency treatment, and promise to hold them harmless and reimburse them for any liability arising there from. The adult leaders or Troop 201 shall advise me of my son's illness or injury as soon as possible. In addition Troop 201 adult leaders may return my son from treatment to camp or home if I am not available.

Hospitalization Coverage \_\_\_\_\_ Group \_\_\_\_\_

Code \_\_\_\_\_ Contract/ID/Record No. \_\_\_\_\_

Blood Type (if known) \_\_\_\_\_ Faith \_\_\_\_\_

Allergies/Other \_\_\_\_\_

Date of last Tetanus vaccination (very important) \_\_\_\_\_

Residence address \_\_\_\_\_ Home Phone \_\_\_\_\_

\_\_\_\_\_ E-mail \_\_\_\_\_

Father or legal guardian \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Mother or legal guardian \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Other Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Relation to Scout \_\_\_\_\_

\_\_\_\_\_  
Signature of Father or Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Signature of Mother or Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

(Please print legibly)

PLEASE SEE OTHER SIDE FOR OVER THE COUNTER MEDICINE  
ADMINISTRATION

# Boy Scout Troop 201 – Olmsted Falls

## Authorization to Administer “Over the counter medicine”

I \_\_\_\_\_ (mother) and  
\_\_\_\_\_ (father) hereby give  
permission to the adult leaders of Boy Scout Troop 201 permission to administer the  
following “over the counter” medications/ or materials to my son.

Mother’s Initial	Mother’s initial Date	Father’s Initial	Father’s Initial Date	Item
				Tylenol
				Ibuprofen
				Benadryl
				Claritin
				Antibiotic cream
				Hydrogen Peroxide (cuts and scrapes)
				Poison Ivy cream
				Baby Powder
				Sun Screen
				Bug Spray (no DEET)
				Bug Spray (with DEET)

I specifically do not **want the** following medications or items administered to my son.

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Please complete the reverse side of this form for prescription medications to be administered. Sign and date both sides of the form. Whenever possible both parents should sign the form.

\_\_\_\_\_ Mother’s Signature \_\_\_\_\_ Date

\_\_\_\_\_ Father’s Signature \_\_\_\_\_ Date

(Please print legibly)