TROOP 125

MEDICAL RELEASE

Name_____DOB_____Age____Parent Name_____
Address_____City_____State___Zip_____
Home Phone_____Work Phone_____Cell Phone_____
Health/Accident insurance company_____Policy #_____

Have or subject to (check if yes)
O Asthma O Fainting spells O Convulsions O Allergy (medication, food, plant, animal, or insects) O Diabetes O Heart trouble O Bleeding disorders O Eyes, ears, nose, throat O Digestion O Bed-wetting O Lungs O Sleep walking O Diet restrictions O ADD/ADHD O Learning difficulties O Other Explain_____
_____

Check here if none of the above apply O

Regular medications taken: NO YES Name of meds_____
Any restriction of activity for medical reasons? NO YES Please explain_____
_____

Immunizations	Date of last Inoculation:	Date of last inoculation:	Date of last inoculation:	Date of last inoculation:
Tetanus toxoid	_____	Polio _____	Mumps _____	Pertusis _____
Diphtheria	_____	Measles _____	Rubella _____	

CONSENT FOR TREATMENT In the event that I/we can not be reached,
1) I/We, the undersigned, parents/legal guardians of _____, a minor, do hereby authorize the adult leader(s) in charge as agent(s) for the undersigned to consent to any X-Ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the Medical Practice Act on the staff of any accredited hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of our aforementioned agent(s) to give the consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his/her best judgment to the provisions of section 25.8 of the Civil Code of California. This authorization shall remain in effect for ONE YEAR from date, unless soon revoked in writing, delivered to said agent(s).

2) I/We certify that the above named minor is physically fit. He has my/our permission to engage in all Scout activities.

Emergency Contacts

Date_____

Name & Phone_____
_____ Name & Phone_____
Signature (parent/legal guardian