

# TROOP 850 PERMISSION SLIP

TROOP 850 is planning: Campout of Calico Ghost Town  
Located at: I-15 at Ghost Town Road  
Troop will meet at McNair's 814 Vista Del Gaviota, Orange Date Sat., March 18, 2006 Time 7:30 a.m.  
Troop will return to McNair's Date Sun., March 19, 2006 Time 3:30 p.m.  
In case of emergency, call Mike McNair (cell phone) 562-477-5247 or Lori McNair (home) 974-5075 (cell) 856-0301

**Commitment:** TURN IN SIGNED PERMISSION SLIP BY TUESDAY, MARCH 7<sup>TH</sup>

**Bring:** - See Campout Packing List in Parent Guide  
- Warm clothes  
- Sack lunch for Saturday  
- Money for patrol food

**Wear:** - Comfortable non-Scout clothes & shoes

*Keep the above information. Complete, sign, and send form below by date indicated.*

**TEAR HERE**

**DAD** \_\_\_\_\_ Yes, I will go, too!

Make & model of car \_\_\_\_\_ Number of seatbelts \_\_\_\_\_

CA Driver's License # \_\_\_\_\_ Driver's cell phone # \_\_\_\_\_

## PARENTS' PERMISSION AND EMERGENCY MEDICAL FORM

I request that my son, \_\_\_\_\_, be permitted to go with Troop 850 on a trip to **Calico Ghost Town on March 18 & 19, 2006**. He is in good physical condition and can participate in this event. Should any illness or accident occur to him on the trip, I will not hold liable the Boy Scout Council of Orange County, its officers, or Troop Leaders and other participating adults for it or for medical aid rendered, and will reimburse the Boy Scout Council of Orange County or Troop 850 for medical or other expenses incurred in the care of my son.

I am ( ) one of the parents having legal custody, I am ( ) the parent having legal custody, I am ( ) the legal guardian (check applicable) of my above-named son, a minor. I hereby authorize the giving of first aid to my son. I further authorize any adult leader of Troop 850 on the above event to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care to be rendered to the minor under the general or special supervision and upon the advice of a physician and surgeon licensed under the provisions of the Medical Practice Act, or to consent to an X-ray examination, anesthetic, dental or surgical diagnosis or treatment and hospital care to be rendered to the minor by a dentist licensed under the provisions of the Dental Practice Act. Parents will be contacted immediately if possible. This authorization is given pursuant to California Civil Code Section 25.8.

Doctor (Name and City) \_\_\_\_\_ Phone \_\_\_\_\_

Christian Science Practitioner (Name and City) \_\_\_\_\_ Phone \_\_\_\_\_

Medical Insurance Carrier \_\_\_\_\_ Policy or I.D. No. \_\_\_\_\_

Date of last tetanus shot \_\_\_\_\_ Allergic to \_\_\_\_\_

Parents' Phone \_\_\_\_\_ Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Dated \_\_\_\_\_ Signature \_\_\_\_\_

Parent or Legal Guardian