BSA Troop 59
Authorization for Trip/Activity, Hold Harmless Agreement & Medical Treatment

TRIP/ACTIVITY AUTHORIZATION: I, the undersigned parent/guardian of ________________________________
authorize his participation in the ____ including travel by motor vehicle.

HOLD HARMLESS AGREEMENT: I understand that participation in the 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.

AGREEMENT FOR MEDICAL TREATMENT: 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. I consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment or hospital care to be rendered to said Scout, under general or special supervision and upon the advise of a Physician and/or Surgeon licensed under the provisions of the Medical Practices Act of the California Business and Professions Code. I consent to an x-ray examination, anesthetic, dental or oral surgery diagnosis or treatment or hospital care to be rendered to said Scout by a Dentist licensed under the Dental Practices Act of the California Business and Professions Code. This authorization is given pursuant to Section 25.8 of the Civil Code of California and it is understood this authorization is given in advance of any specific need for the benefit of said Scout.

I hereby authorize the trip/activity; agree to the Hold Harmless Agreement and Agreement for Medical Care:

Name: ___________________________ Signed: ____________________ Dated: ___ / ___ / ___

Address: ______________________________________ City: ________________ Zip: _______

Home Phone: ______ - ______ - _________ Work Phone: _______ - _______ - _______

Mobile Phone: ______ - ______ - _________ Pager #: _______ - _______ - _______

Doctor: ________________________________ Doctor's Phone: _______________________

Medical Insurance Company: ______________________________ Policy #: _________________

Medical conditions, Allergies, etc.: ____

I _______________________ will attend with my son. I will not attend

I cannot provide transportation

I can provide transportation To From

I can transport __________ scouts plus to my son. My vehicle has ____ safety belts.

Vehicle Insurance Company Name _________________________ Driver's Cell #___________________

Insurance Limits $______________________ / $______________________ / $__________________
Liability/Each Person (Min $50,000) Liability Each Accident (Min $100,000) Property Damage (Min $50,000)

Year, Make & Model of Vehicle ______ _________________ __________________________

Vehicle License Number ____________________ Drivers License Number ____________________

Date Paid_________ Amount Paid $___________ Check # or Cash _______________