



## Event/Trip Permission Form

My son, \_\_\_\_\_, has permission to participate in any Troop 42 event or trip as long as my initials appear on the bottom of this form. He is in good physical condition and has not had any serious illness or operation since his last health examination. During the activity, I may be reached at:

Address: \_\_\_\_\_  
 Home Phone: (\_\_\_\_) \_\_\_\_\_  
 Cell Phone: (\_\_\_\_) \_\_\_\_\_

If I cannot be reached in the event of an emergency, the following person is authorized to act in my behalf:

Name: \_\_\_\_\_  
 Relationship: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Home Phone: (\_\_\_\_) \_\_\_\_\_  
 Cell Phone: (\_\_\_\_) \_\_\_\_\_

Physician:  
 Phone: (\_\_\_\_) \_\_\_\_\_

Insurance Company: \_\_\_\_\_  
 Policy/Group #: \_\_\_\_\_

I give my permission for each of the following that I have checked:

- My son's participation in regular Troop 42 activities.
- If I cannot be reached in an emergency, I authorize a physician selected by the adult in charge to secure proper treatment and to order injection, anesthesia, or surgery for my child.
- I understand that if my son is found using drugs or alcohol or is behaving in a manner which is dangerous to himself or his troop members, he will be sent home at parent expense.
- Use of my son's photograph or voice for publicity purposes.

All medicines (with dosage instructions) must be given to event first aider upon arrival.

Signature of Parent or Guardian

Date

\_\_\_\_\_


# Health History

**ILLNESS AND INJURIES:** Chronic or recurring (Check all that apply)

- |   |  |
|---|--|
| <input type="checkbox"/> Ear infection              | <input type="checkbox"/> Hypertension              |
| <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Musculoskeletal disorders |
| <input type="checkbox"/> Heart defect/disease       | <input type="checkbox"/> Seizures                  |
| <input type="checkbox"/> Asthma                     | <input type="checkbox"/> Other                     |
| <input type="checkbox"/> Bleeding/clotting disorder |  |

**OTHER HEALTH CONDITIONS** (Check all that apply)

- |   |  |
|---|--|
| <input type="checkbox"/> Emotional disturbances (list)<br>_____ | <input type="checkbox"/> Wears glasses or contacts |
| <input type="checkbox"/> Constipation                           | <input type="checkbox"/> Bed wetting               |
| <input type="checkbox"/> Motion sickness                        | <input type="checkbox"/> Fainting                  |
| <input type="checkbox"/> Special dietary needs (list)<br>_____  | <input type="checkbox"/> Hearing impairment        |
|   | <input type="checkbox"/> Nosebleeds                |
|   | <input type="checkbox"/> Sleep disturbances        |

**ALLERGIES** (Check all that apply and specify)

- |  |  |
|--|--|
| <input type="checkbox"/> Animals _____   | <input type="checkbox"/> Medicines/drugs _____ |
| <input type="checkbox"/> Hay fever _____ | <input type="checkbox"/> Insect stings _____   |
| <input type="checkbox"/> Food _____      | <input type="checkbox"/> Plants _____          |
| <input type="checkbox"/> Pollen _____    | <input type="checkbox"/> Other _____           |

**IMMUNIZATION HISTORY:**

Is the applicant's immunization record up-to-date?

- Yes    No

**OTHER INFORMATION**

Explain any conditions checked on form. Give information helpful to adult in charge. Indicate activities to be restricted. \_\_\_\_\_

I know of no reason, other than the information on this form, why my son should not participate in prescribed activities; except as noted: \_\_\_\_\_

My son may be given

- Non-aspirin product  
 Benadryl  
 Antacid