MEDICAL INFORMATION/INFORMED CONSENT

Name _____
(First) (Middle initial) (Last)

Telephone (_____) _____ (_____) _____
(Home) (Work)

Personal physician _____ Phone (_____) _____
(Name)

In case of emergency, please contact _____ Phone (_____) _____

Special dietary considerations _____

_____

List known allergies _____

_____

List required medications _____

_____

If you are allergic to bee stings, do you have a bee sting kit? _____

Do you wear contact lenses? _____ Are you pregnant? _____

Have you had or do you now have (circle if yes): Heart attack Diabetes Asthma
Angina Epilepsy Chest pains Drug reactions High blood pressure Heart murmur

If you answered yes to any of the above, explain and include date _____

_____

Do you have any other medical conditions that we should be aware of? _____

_____

I am not under the influence of any chemical substance, including alcohol. Understanding that any physical activity involves a risk of injury, I understand that my participation in the (name any council) Project COPE program is entirely voluntary. I release (name any council), its employees, and staff from any claims or liability arising out of my participation. This release does not, however, apply to any harm caused by negligence or willful misconduct of (name any council) or its employees.

Name _____
(Please print.)

Course/company _____

Participant's signature* _____ Date _____

*If the participant is under age 18, his or her parent or guardian must also sign below:

Parent's or guardian's signature _____ Date _____

PARENTAL INFORMED CONSENT AND HOLD HARMLESS/RELEASE AGREEMENT

I understand that participation in the _____(activity) offered through the _____ Council, BSA, on _____(date) involves a certain degree of risk that could result in injury or death. In consideration of the benefits to be derived and after carefully considering the risk involved and in view of the fact that the Boy Scouts of America is an organization in which membership is voluntary, and having full confidence that precautions will be taken to ensure the safety and well-being of my (son/daughter), I have carefully considered the risk involved and have given _____(name of son/daughter) my consent to participate in _____(activity), and waive all claims I may have against the Boy Scouts of America, _____ Council, activity coordinator(s), all employees, volunteers, or other organizations associated with the _____(activity).

In case of emergency, I understand every effort will be made to contact me. In the event I cannot be reached, I hereby give my permission to the physician selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child.

This form must have signatures of both parents or guardians.

_____ Signature

_____ Signature

_____ Date

_____ Date