

PACK 657 PARENT PERMISSION SLIP

EVENT: _____

DATES: from _____, 2003 _____ am/pm to _____, 2003 _____ am/pm

LOCATION: _____

SCOUT _____ **SSN:** _____

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

SIGNATURE: _____ **Date** _____

EMERGENCY CONTACT _____ **Tel#** _____ **Relationship** _____

MEDICAL / HOSPITALIZATION INSURANCE INFORMATION

List of Medicines and attached directions for use:

List of Medicines my son is allergic to: _____

List of items my son is allergic to _____

Name of Insurance Company _____

Policy Number _____ Group Number _____

Name of Insured _____ SSN _____

Insured Employer _____ Tel. No. _____

Insured Employer Address _____

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