Troop 615 Consent for Emergency Medical Treatment and Waiver of Liability

This form is a supplement to Part C of the Boy Scout of America (BSA) Annual Health and Medical Record Part C, Informed Consent and Hold Harmless/Release Agreement.

Permission is hereby granted to the officers, leaders or agents of the Bay Area Council, BSA, to obtain and administer such medical assistance as might, in their judgment, be required, for the immediate care of our son or myself in the event that help of an emergency nature becomes necessary. This authorization is granted with the knowledge that at certain locations used or administered by the Bay Area Council, BSA, medical assistance from a licensed physician or dentist may not be readily available.

Medication Form

At any campout, medication (prescription and over-the-counter) must be in the ORIGINAL labeled container and placed in a zip-lock type bag identified with the Scout's name.

☐ NO medications are to be given (including over-the-counter)

☐ Authorize administration of medications as indicated on the BSA Part A, Medications form.

☐ Authorize administration of over-the-counter medications including, but not limited to, Ibuprofen, Acetaminophen, Antacid, Decongestant, and topical medications including, but not limited to, Calamine and Chloramphenicol.

Eyeglasses/Contacts Replacement Authorization

Scouts should always be prepared. Scouts that wear glasses/contacts will have a spare pair of glasses/contacts in their camping gear.

☐ My child does not wear glasses or contacts

☐ If my child does not have a spare pair of glasses/contacts, I understand I may be called to pick up my scout from the activity.

☐ I am attaching a prescription that may be used to purchase glasses/contacts in the event that my scout's glasses/contacts are destroyed. I expect to be called prior to purchase and understand I will be responsible for the replacement cost.

Parent/Legal Guardian/Participant Signature

I have read and understand the text of the informed consent for emergency medical treatment and waiver of liability above and agree to the terms stated without reservation. I consent to the administration of medications and eyeglasses/contacts replacement authorization.

Printed Name of Participant (Youth)	Printed Name of Parent/Participant (Adult)
	Primary Contact Number: _____
Signature of Parent/Legal Guardian	Alternate Contact Number: _____
	Alternate Contact Person: _____
Date	Phone number: _____
Witness	Date

Last Name: _____ DOB: _____