

Troop One, B.S.A.
Medical Treatment Authorization for an Adult

In the event of a medical emergency, I hereby authorize, and agree to be financially responsible for: emergency first aid; medical examination; x-ray, MRI, or CT scan; anesthetic; hospitalization; and any medical, surgical, or dental diagnosis, treatment, or care rendered by or under the supervision of licensed medical personnel and considered necessary on my behalf. I understand that a reasonable effort will be made to contact family or loved ones at the phone number(s) listed below.

Name of Adult: _____ Birth Date of Adult: _____

Doctor: _____ Doctor's phone: _____

HMO / Insurance Co: _____

Subscriber / Policy number: _____

Dentist: _____ Dentist's phone: _____

I am allergic to: _____

I am currently taking the following medications and wonder drugs (optional): _____

Other medical conditions: _____

I agree to accept the risks that accrue with this adventure, and to participate and assist in the outing, subject to these limitations: _____

Printed name: _____

Signed: _____ Date: _____

Emergency contacts. Please list names, relationship, home & cell phones: _____
