

Troop One, B.S.A.  
Medical Treatment Authorization for a Scout

In the event of a medical emergency, I understand that a reasonable effort will be made to contact me at the phone number(s) listed below. If I cannot be contacted immediately, 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 for my son.

Name of Scout: \_\_\_\_\_ Birth date of Scout: \_\_\_\_\_

Doctor: \_\_\_\_\_ Doctor's phone: \_\_\_\_\_

HMO / Insurance Co: \_\_\_\_\_

Subscriber / Policy number: \_\_\_\_\_

Dentist: \_\_\_\_\_ Dentist's phone: \_\_\_\_\_

\_\_\_\_\_ [name] is allergic to \_\_\_\_\_

\_\_\_\_\_ [name] is currently taking the following medication(s): \_\_\_\_\_

- He may administer it to himself. OR  
 I give my permission for an adult Scout leader to administer it for him.

\_\_\_\_\_ [name] must not participate in the following activities because of health limitations:

- Required immunizations are all current.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

[Parent or Guardian]

Printed name of Parent or Guardian: \_\_\_\_\_

Weekend and Emergency contact phone numbers: Home: \_\_\_\_\_

Cell: \_\_\_\_\_

Please list all numbers that might facilitate contacting a parent or other responsible party in an emergency. Complete the parental permission form for the outing on the preceding page.