

BSA Troop 843 Outing Permission Form

Outing:	Rappelling Outing
Date(s):	Friday, Sept. 8 through Sunday, Sept. 10, 2006
Location:	Conkle's Hollow State Park, Hocking Hills area
Cost:	\$15.00 to rappel, \$4.00 adult/youth to camp
Register by:	Monday, August 28, 2006
ESA:	Dave Ivancic, 740-363-3836 or dgivancic@juno.com
Depart from:	Meet at LCUMC Friday Sept. 8 at 5:30 PM, leave 6:00 PM
Return to:	LCUMC Sunday Sept. 10 around noon
Notes:	All meals at camp except Saturday lunch. Bring sack lunch, water, and day pack for Saturday hike to rappelling area.

Scout Name:	
Parent Name (if attending):	
Drive to event (Y/N)	
Drive from event (Y/N)	
Vehicle and # of seat belts:	
Driver's License #:	
Driver's Licence state:	
Mimimum insurance (Y/N)	

Emergency Contact Information

Parent Name:	
Home Phone:	
Cell/Pager:	
Alternate Contact:	
Home Phone:	
Doctor Name/Phone:	
Dentist Name/Phone:	

Amount paid: \$ _____ by cash, check, scout account (circle one)

Informed Consent, Hold-Harmless Agreement, and Consent for Medical Care

I understand that participation in activities offered through Troop 843, Boys Scouts of America, involves a certain degree of risk. 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, I give (Scout's name) _____ my consent to participate in the Rappelling Outing on Friday Sept. 8 through Sunday Sept. 10, 2006. I discharge and release Troop 843, the Simon Kenton Council, the Boy Scouts of America, and all other organizations or persons connected with this activity from all claims for personal injury, loss or inconvenience resulting from my son's participation. I further understand that, in case of emergency, every effort will be made to contact me. In the event I cannot be reached, I hereby give my permission to the licensed health-care practitioner selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my son. This form must have both parent's/guardian's signatures.

Name (please print)

Name (please print)

Signature

Signature

Date

Date

Telephone number with area code

Telephone number with area code