Troop 1 Hopedale – Permission Slip

Event: **Cape Cod Bike and Fishing Trip**

Arrive @ Church: **Friday, May 8, 2009, 5:30 PM**

Pick-up @ Barney Coal: **Sunday, May 10, 2009 10:00 AM (approximate, will call)**

- **What to Bring:**
  - **Personal Gear in a backpack;**
  - **Lean-to camping;**
  - **Bring bicycle, boots for hiking, fishing gear**
  - **Might be cold along the beach**
  - **Dinner for Friday Night**

Cost: **$10**

Permission Slip Due: **May 5, 2009**

Emergency Phone : **Tom Wesley 508-615-9870 (mobile)**
Mark Andolina 774-573-2623

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BOY SCOUTS OF AMERICA KNOX TRAIL COUNCIL

PARENT / GUARDIAN CONSENT AND APPROVAL FOR SCOUT ACTIVITY

(Applies to all persons under the age of 18)

Date: _____

Scout's Name: _____

Address: _____

Date of Birth:_____ Home Phone:_____ Alternate Weekend Phone:_____

Has my permission to participate in the camping trip, to be held April 8-10, 2009 at Truro, Cape Cod, MA, for biking and Fishing.

AUTHORIZATION AND CONSENT TO TREAT A MINOR

The undersigned does hereby authorize the Scoutmaster or such substitute as he may designate, as agent for the undersigned to consent to any x-ray, examination, anesthetic, medical or surgical diagnosis or treatment and hospital care for the above minor which is deemed advisable by and to be rendered under the general or special supervision of any physician and surgeon, licensed under the provision of medicine practice act or a dentist licensed under the dental practice act, whether such diagnosis or treatment is rendered at the office said physician or dentist, at a hospital, or elsewhere. Every effort will be made to contact a parent or guardian prior to this authorization being given. This authorization will remain effective while the above minor is en route to or from, or involved or participating in, **the camping trip, to be held April 8-10, 2009 at Truro, Cape Cod, MA, for biking and Fishing.**

Signed_____ (Parent or Guardian)

Print Name_____

Relationship to Scout_____

IN CASE OF EMERGENCY AND PARENTS/GUARDIANS CANNOT BE CONTACTED, PLEASE NOTIFY:

Name_____ Telephone_____

Relationship _____

Physician's Name _____ Telephone_____

Allergies or Other Conditions_____

Medical Insurance Information_____

Company/Provider_____ Policy Number_____

COST: $10 per person **PAID _____**