



**Boy Scouts of America – Orange County Council  
TROOP 12  
MEDICAL/PERMISSION FORM**



**IDENTIFICATION**

Name \_\_\_\_\_ Date of birth \_\_\_\_\_ Age \_\_\_\_ Sex \_\_\_\_

Name of Parent or Guardian \_\_\_\_\_ Phone \_\_\_\_\_

Home address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Insurance \_\_\_\_\_ Policy No. \_\_\_\_\_

**IN CASE OF EMERGENCY**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Name of physician \_\_\_\_\_ Phone \_\_\_\_\_

**EMERGENCY MEDICAL INFORMATION**

- Allergies to food, drugs, plant, animals, or insects (circle). Explain: \_\_\_\_\_
- Any condition that may require special care, or diet. Explain: \_\_\_\_\_
- Current medications: \_\_\_\_\_
- Any condition that adult leaders should be aware of? \_\_\_\_\_
- Immunizations: Tetanus: \_\_\_\_\_ Other: \_\_\_\_\_

**PERMISSION**

I, (Parent/Guardian) of the above-named Scout, give permission for full participation in Troop 12 BSA programs, subject to the limitations noted herein, from January 2010 to December 2010.

Limitations: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

In case of emergency, I understand that every effort will be made to contact me. In the event that I cannot be reached, I hereby give my permission to the licensed health practitioner, selected by the adult leader in charge, to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child.

Dated: \_\_\_\_\_

\_\_\_\_\_  
 (Print name)

\_\_\_\_\_  
 (Sign name)