Authorization Form

This is to acknowledge that my son, _____ has permission to participate in all activities of Troop 313 of the Boy Scouts of America, including meetings, outings, trips, camping, hiking, water sports, etc. He is in good condition at present and I/we authorize emergency medical treatment and agree to pay all costs associated with the medical treatment.

Summary of Medical History: Date of Birth: _____

Has or subject to: *(Check if **YES**)*
_____ asthma _____ fainting spells _____ convulsions
_____ allergy to or reaction to medications.
Identify _____

Has difficulty with: *(Check if **YES**)*
_____ eyes, ears, nose, throat _____ digestion _____ lungs
_____ sleepwalking _____ bed wetting

Any condition now requiring regular medications? Y/N
Medication Name: _____

Date of Last Tetanus Inoculation: _____

Primary Information: For purposes of emergency notification

Parent or Legal Guardian: _____

Primary Address: _____
Street

_____, MO _____
City Zip

Day Telephone: _____ Night Telephone: _____

Insurers Name: _____ Policy Number: _____

Primary Parent or Legal Guardian:

_____
Signature (Date)

_____
(Name Printed)

Primary Parent or Legal Guardian:

_____
Signature (Date)

_____
(Name Printed)

I, the undersigned, a Notary Public in and for said county and state aforesaid, DO HEREBY CERTIFY _____, personally known to me to be the same person(s) whose name(s) are subscribed to the foregoing instrument, appeared before me this day in person and acknowledged they signed, sealed, and delivered the foregoing instrument as their free and voluntary act for the uses and purposes therein set forth.

GIVEN under my hand and notarial seal this day of , 20

My commission expires:

_____**(SEAL)**
NOTARY PUBLIC

SECONDARY INFORMATION:

Secondary Parent or Legal Guardian: _____

Primary Address: _____
Street

_____, _____, MO _____
City Zip

Day Telephone: _____ Night Telephone: _____

OVER THE COUNTER MEDICATION PERMISSION:

I hereby give my permission to the Scoutmaster or his designated assistant to provide the following over-the-counter medication to my son in the event of a minor illness.

____ cold medication (i.e., decongestant, antihistamine)
____ anti-itch medication (i.e., benedryl)
____ headache or pain (i.e., acetaminophen/Tylenol)
____ other _____
____ cough medication
____ sore throat medication
____ allergy medication

Please list all over-the-counter medications that your son SHOULD NOT be given.

_____

_____

_____

_____
Parent's Signature