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## Troop 2, Milford, MA / Knox Trail Council BSA 2010 Scouter Emergency – Medical Slip

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Scouter \_\_\_\_\_ Address \_\_\_\_\_

City / Town \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Health / Accident Insurance Co. \_\_\_\_\_ Policy No. \_\_\_\_\_

MD Name \_\_\_\_\_ Phone No. \_\_\_\_\_

**Have or subject to (check if yes):**

Asthma  Fainting Spells  Convulsions  Diabetes  Heart Trouble  Bleeding Disorders

Condition that may require special care, or diet **Explain:** \_\_\_\_\_

Allergy to any:  medication  food  plant  animal  insect toxin

**Have difficulty with (check if yes):**  eyes, ears nose or throat  digestion  lungs  sleep walking

**Explain:** \_\_\_\_\_

**Check here if none of the above applies**

Any condition now requiring regular medication?  Name of Medication \_\_\_\_\_

Any restriction of activity for medical reasons?  **Explain:** \_\_\_\_\_

**Please use reverse side for further explanations of conditions and/or medication if needed**

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**SCOUTER AUTHORIZATION: I have read, understand, and agree to the following waiver:**

In consideration of the benefits to be derived for the Scouts with the guidance of the Scouters, I have full confidence that every precaution will be taken to insure my safety and well being with my involvement with various activities. I agree that my participation is voluntary and I will hold the Troop harmless for all sponsored activities. Further, I waive any and all claims against the leaders of this trip and officers, agents, and representatives of the Boy Scouts of America.

This health history is correct as far as I know, and I am willing to engage in all prescribed activities, except as noted above. In the event of an emergency, I hereby give permission to the physician, selected by the adult leader in charge, to hospitalize, secure proper anesthesia, or to order injection for myself.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**I authorize ONLY the following people to be contacted in an emergency:**

NAME	RELATIONSHIP	PHONE NO.
_____	_____	(    ) _____
_____	_____	(    ) _____
_____	_____	(    ) _____