

AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR

(Pursuant to California Civil Code Section 25.8 and California Penal Code Section 12552)

Scout's Name: _____ **Date of Birth:** ____/____/____

Home Address: _____
(Street Address) (City) (ZIP)

The undersigned does hereby authorize the Scoutmaster of Troop 5, BSA, or any such substitute as he may designate, as agent for the undersigned to consent to any x-ray examination, anesthetic, medical, dental, and surgical diagnosis and 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 or surgeon, licensed under the provision of Medical Practice Act, or of any dentist licensed under the Dental Practice Act, whether such diagnosis or treatment is rendered at the office of said physician or dentist, at a hospital, clinic, scout camp or elsewhere. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power on the part of my (our) aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician or dentist in the exercise of his/her best judgement may deem advisable. The Scoutmaster or his designate will make all reasonable attempts to contact the scout's parents or guardian prior to treatment.

This authorization will remain in effect while the above minor is enroute to and from, involved or participating in any Boy Scout Program or Activity of Troop 5 or Pacific Skyline Council of BSA.

This authorization will remain in effect for 13 months from the date of signature below unless it is revoked sooner in writing by the undersigned and delivered to the aforesaid agent.

Father (or Guardian): _____ **Mother (or Guardian):** _____

Home: (____) ____ - ____ Work: (____) ____ - ____ Home: (____) ____ - ____ Work: (____) ____ - ____

Emergency Contact I: _____ **Emergency Contact II:** _____

Telephone(s): _____

Family Medical Insurance:

Insurance company: _____ Primary insured: _____

Certificate or group no.: _____ Policy no.: _____ Effective date: _____

Phone no. for authorization (if required): _____ Scout's medical record no.: _____

Medical History:

Serious Illnesses: _____

Date of last tetanus shot: (mo./yr.) _____ Medication allergies: _____

Food allergies: _____ Insect or sting allergies: _____

Medications taken regularly: _____ Impairments: _____

Scout wears (circle if applies): glasses contact lenses retainer hearing aid _____ (other)

Regular Physician: _____ Phone(s): _____

Address: _____

Give permission to take non-prescription medicines by initialing after name:

Acetaminophen (eg. Tylenol) for pain or fever_____, Peptobismol or Mylanta (for upset stomach)_____, Sudafed (for nasal congestion)_____, Dramamine (for motion sickness)_____, Chlortrimeton (for itching and allergic reactions)_____ Others (please write in): _____

Signature of Parent or Guardian

Signature of witness

Date: ____/____/____

Date: ____/____/____