



# 2008 Philmont Expedition 618-B Permission Slip and Medical Release/Waiver

Crew 445 & Troop 445 – Venturers and Scouts under 21 years of age

\_\_\_\_\_ has my permission to participate in  
(Name of Scout or Venturer)  
all 2008 Philmont Expedition 618-B related activities with Crew 445/Troop 445 between the dates of January 1, 2008 and June 30, 2008.

I certify that this Venturer/Scout can meet the health and physical requirements of the trip or activity.

### Water Activities:

In the event any activity takes place in total or in part on or near water, I certify that this Venturer/Scout is:

(Check one): \_\_\_ nonswimmer \_\_\_ beginner swimmer \_\_\_ advanced swimmer \_\_\_ BSA lifeguard

### Waiver of Claims:

In consideration of the benefits to be derived from participation in this trip or activity, any and all claims against the Boy Scouts of America or its local councils, BSA Troop 445, Venture Crew 445, and the chartered organization, or against the officers, employees, agents, or other representatives of any of them, or any other persons working under their direction or engaged in the conduct of their affairs, arising out of any accident, illness, injury, damage, or other loss or harm to/or incurred or suffered by the applicant named above or to his or her property, in connection with or incidental to the Troop/Crew trip or activity, including preliminary training and travel, are hereby expressly waived by the applicant and the applicant's family or guardians.

### Medical Release:

In the event of illness or injury occurring to my son or daughter while involved in this trip or activity, I consent to X-ray examination, anesthesia, and/or medical or surgical diagnostic procedures or treatment that is considered necessary in the best judgment of the attending physician and performed by or under the supervision of a member of the medical staff of the hospital furnishing medical services. It is understood that in the event of serious illness or injury, reasonable efforts to reach me will be attempted.

Personal Physician: \_\_\_\_\_

Telephone number: \_\_\_\_\_

### Parental Approval:

\_\_\_\_\_  
(Signature of parent or guardian)

\_\_\_\_\_  
(Date)

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone numbers where I can be reached during the time of this activity:

Home ( \_\_\_\_\_ ) \_\_\_\_\_

Work ( \_\_\_\_\_ ) \_\_\_\_\_

Cell ( \_\_\_\_\_ ) \_\_\_\_\_

Emergency ( \_\_\_\_\_ ) \_\_\_\_\_

Emergency contact: \_\_\_\_\_

### Health Insurance Information & Medical History:

Insurance Company: \_\_\_\_\_

Participant's DOB: \_\_\_\_\_

Group Number: \_\_\_\_\_

Participant's allergies: \_\_\_\_\_

Member Number: \_\_\_\_\_

Participant's medical conditions: \_\_\_\_\_

Primary Insured: \_\_\_\_\_

Medications participant regularly takes: \_\_\_\_\_

### Notary Public (if required):

Subscribed and sworn to before me on this the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

My commission expires \_\_\_\_\_, 20\_\_\_\_\_. Signature of notary public: \_\_\_\_\_