



**OUTDOOR ACTIVITY NOTICE & PERMISSION SLIP**

**ACTIVITY:** \_\_\_\_\_ **FEE:** \_\_\_\_\_  
(CASH PLEASE)

**LOCATION:** \_\_\_\_\_

**DEPARTURE FROM:** \_\_\_\_\_

**DATE:** \_\_\_\_\_ **TIME:** \_\_\_\_\_

**RETURN TO:** \_\_\_\_\_ **DATE & TIME:** \_\_\_\_\_

**ADULT LEADER IN CHARGE:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

**EMERGENCY CONTACT:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

-----TEAR HERE, RETAIN TOP PORTION & RETURN BOTTOM PORTION-----

**PERMISSION**

My scout (Name/Date of Birth/Age) \_\_\_\_\_

has my approval to participate in (activity & dates) \_\_\_\_\_.

**HOLD HARMLESS AGREEMENT**

I understand that participation in the activity involves a certain degree of risk. I have carefully considered the risk involved and have given consent for myself or my child to participate in the activity. I understand that participation in the activity is entirely voluntary and requires participants to abide by applicable rules and standards of conduct. I release the Boy Scouts of America, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with the activity from any and all claims or liability arising out of this participation.

In case of emergency involving my child, I understand every effort will be made to contact me. In the event I cannot be reached, I hereby give my permission to the medical provider selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child. Medical providers are authorized to disclose to the adult in charge examination findings, test results, and treatment provided for purposes of medical evaluation of the participant, follow-up and communication with the participant's parents or guardian, and/or determination of the participant's ability to continue in the program activities.

**MEDICAL INFORMATION**

I certify that my son is in good physical condition. If needed, my son may be administered with over the counter medicines such as Tylenol, Benadryl, Imodium AD, sunscreen and other topical medication. \_\_\_\_\_ (Initials)

Additional medical information regarding my son (if none, please indicate the same):

Allergies/Drug Reactions \_\_\_\_\_

Recent Illnesses \_\_\_\_\_

Current Prescription Drugs \_\_\_\_\_

Participant's signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/guardian printed name: \_\_\_\_\_

Parent/guardian signature \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Area code and telephone number (best contact and emergency contact)

\_\_\_\_\_  
E-mail (for use in sharing more details about the trip or activity)