

**CONSENT FORM  
APPROVAL BY PARENTS OR GUARDIANS**

\_\_\_\_\_  
 First name of BSA member/guest and middle initial Last name

\_\_\_\_\_  
 Address Birth date (month/day/year)

\_\_\_\_\_  
 City State Zip

(\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
 Area code and telephone no. (parent's business no.) Area code & telephone no. (home)

(\_\_\_\_\_) \_\_\_\_\_  
 Phone # where I can be reached during activity

**FOR:** \_\_\_\_\_ TRIP DESTINATION \_\_\_\_\_  
**ON:** \_\_\_\_\_ DATE \_\_\_\_\_

**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, pack, troop, team, crew, and 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 trip or activity, including preliminary training and travel, are hereby expressly waived by the applicant and the applicant's family or guardians.

I hereby approve and agree to all of the terms, conditions, and waiver of claims of this consent form and certify to its correctness. Further, I agree that this BSA youth member or guest can meet the health and physical fitness requirements of the trip or activity.

**Father/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

or

**Mother/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**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 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.

It is understood that in the event of a serious illness or injury, reasonable efforts to reach me will be attempted.

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

Policy No. \_\_\_\_\_

Physician \_\_\_\_\_

Telephone No. (\_\_\_\_\_) \_\_\_\_\_

Physician