

SCOUT HEALTH HISTORY PERMISSION TO TREAT

Scout's Full Name: _____

Male _____ Female _____ Date of Birth _____

Present Address: _____

Phone: _____ Date: _____

My child has the following diagnosed medical condition (s): _____

My child takes the following medications (prescription or not) on a regular basis:

My child has the following known allergies: _____

Please provide the following information about your family's Health Care insurance (Please attach a copy of your insurance card):

Company Name: _____

Policy Owner: _____

Policy Number: _____

Father's Daytime Phone: _____ Time at this phone: _____

Father's Night Phone: _____ Cell: _____

Mother's Daytime Phone: _____ Time at this phone: _____

Mother's Night Phone: _____ Cell: _____

If an emergency medical situation arises, and neither parent is available by phone, name and phone number of another contact person:

Name: _____ Phone: _____

I authorize the adult leadership of Boy Scout Troop 987 to seek emergency medical treatment for my child.

Parent/Guardian Signature: _____ Date: _____