

Cub Scout Information and Medical Care Permission Form 2010-2011

Scout Name: _____ Grade in September: _____
Date of Birth: _____

Address: _____ Phone: _____
E-Mail Address: _____

Father's Name: _____ Mother's Name: _____
Father's work #: _____ Mother's work #: _____
Father's cell #: _____ Mother's cell #: _____

If parents can't be reached, please notify:
Name: _____ Phone: _____
Name: _____ Phone: _____

Name of Doctor: _____ Phone: _____
Health Insurance: _____ Policy #: _____

Medical Information – please check all that apply and explain below

- Allergy to medicine, food, plant, animal or insect toxin
- Any condition that may require special care, equipment, medication or diet
- ADHD Asthma Convulsions Dentures
- Heart Trouble Contact Lenses Diabetes
- Fainting Spells Bleeding disorders

Explanation (Use reverse side if necessary): _____

In case of emergency, I understand every effort will be made to contact me. In the event that I cannot be reached, I hereby give permission to the physician selected by the adult leader in charge to secure proper medical treatment for my son, including hospitalization, anesthesia, surgery or the injection of medication

As you are aware, scouting is a volunteer partnership between the boys and adults. This program relies on significant adult involvement. Please indicate below how you can help:

- Den Leader or Asst. Den Leader
- Outing Chair (Help organize a trip!)
- Pinewood Derby
- Public Relations Chair
- Refreshment Chair (2 events during the Scout year)
- Other skills and talents you can share with the Pack _____

Date: _____ Signature of Parent: _____