# ACTIVITY CONSENT FORM AND APPROVAL BY PARENTS OR LEGAL GUARDIAN

Boy Scout Troop 777

RETURN BY: **TUESDAY, APRIL 4, 2017**

**ACTIVITY:** Golden Eagle District Camporee - Schabarum Regional Park

**ADULT LEADER CONTACT:**

| NAME: | PHONE: | EMAIL: |
|---|---|---|
| Darmo Tandjung | 714-642-2250 | tdarmo@gmail.com |
| Tedd Wong | 951-733-6562 | wongtheo@yahoo.com |

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| LEAVING FROM | | DATE/TIME | | DATE/TIME |
|---|---|---|---|---|
| Corner of CVS/Smart & Final | AT | Apr 21, 2017 5:30pm | RETURNING | Apr 23, 2017 10:00am |

| TRANSPORTATION FEE | | EVENT FEE | | FOOD COST | | TOTAL COST |
|---|---|---|---|---|---|---|
| -- | + | 16 | + | 12 | = | 28 (Scout) |
| -- | + | 16 | + | 15 | = | 31 (Adult) |

**SPECIAL INSTRUCTIONS:** BRING 10 ESSENTIALS, HANDBOOK,PATROL FLAG, CLASS A & B UNIFORMS. MEDICAL A&B HAS TO BE CARRIED BY EACH SCOUT THROUGHOUT THE ENTIRE EVENT.

## HOLD HARMLESS AGREEMENT

I understand that participation in Scouting activities involves a certain degree of risk and can be physically, mentally, and emotionally demanding. I have carefully considered the risk involved and have given consent for myself or my child to participate in this activity. I also understand that participation in this 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.

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PARTICIPANT NAME ______ BIRTH DATE (MM/DD/YYYY) ______ AGE DURING ACTIVITY ______

ADDRESS ______ CITY, STATE ZIP ______

HAS APPROVAL TO PARTICIPATE IN THE ABOVE STATED ACTIVITY

- [ ] WITHOUT RESTRICTIONS
- [ ] SPECIAL CONSIDERATIONS OR RESTRICTIONS: ______

PARTICIPANT SIGNATURE ______ DATE ______

PARENT/GUARDIAN PRINTED NAME ______ PARENT/GUARDIAN SIGNATURE ______ DATE ______

AREA CODE AND PHONE NUMBER (best contact and emergency contact) ______ EMAIL (For use in sharing more details about activity) ______

## TRANSPORTATION

(please provide all information)

I CAN PROVIDE TRANSPORTATION:

- [ ] TO AND FROM
- [ ] TO ONLY
- [ ] FROM ONLY

YEAR & MAKE OF VEHICLE ______ DRIVERS LICENSE # ______ TOTAL # OF PASSENGERS ______

EACH PERSON ______ EACH ACCIDENT ______ PROPERTY DAMAGE ______

**PUBLIC LIABILITY**

- [ ] **INSURANCE MEETS OR EXCEEDS MINIMUM STATE REQUIREMENTS**

BOY SCOUTS OF AMERICA