



Boy Scout Troop 13, Chippewa Falls, WI *Authorization for Emergency Medical Treatment*

Scout Name: _____

Date of Birth: ____/____/____ Home Phone: (____)____-____

Address: _____ City, State, Zip: _____

I, being the parent or legal guardian of the above named minor, do hereby appoint any appointed leader of Troop 13 to act in my behalf in authorizing unexpected medical, dental, surgical care, and hospitalization for the above named minor during a scouting event in my absence.

This document shall be presented to a physician, dentist, or appropriate hospital representative at such time as unexpected medical, dental, surgical care, or hospitalization may be required.

Parent's/Guardian's Name (Please print): _____

Parent's/Guardian's Signature: _____ Date: _____

Parent's/Guardian's Signature: _____ Date: _____

Medical information:

Date of last tetanus booster: _____

The Scout is allergic or sensitive to: _____

Any limitations or restrictions of activities: _____

Other information or special instructions: _____

Insurance information:

Insurance Co: _____ Policy Number: _____

Or Government Program I.D. Or Contract Number: _____

Contact information:

Parent Workplaces: _____ (____)____-____

_____ (____)____-____

Parent Cell Phones: _____ (____)____-____

_____ (____)____-____

Family Physician: _____ (____)____-____

Other Emergency Contact: _____ (____)____-____

Other Emergency Contact: _____ (____)____-____