

**TROOP 280**  
**PERMISSION SLIP AND MEDICAL FORM**  
**Activity/Outing: Boyd's Cabin      Date(s) April 17-19, 2009**

**This is a BSA Event**  
Medical Forms are required for all attendees

**Meet:**      6:30 PM Friday, Apr. 17 at Mentor United Methodist Church

**Leave:**      7:00 PM Friday

**Return:**    Approx. 10:30 AM Sunday, Apr. 19 at K-Mart front parking lot

**COST:**      \$20 per Participant

**DO NOT OVERPACK**

**Required Gear:**    Normal camping gear, Rain gear, Camp chair  
Ground cloth/tarp

**Program:**      Wilderness Survival Camping. Friday Night: sleep in the tent. Saturday Night: sleep in the survival shelter YOU build. Breakfasts & Dinner: Troop Cook, Lunch: Troop will provide food for survival cooking: ground beef, fruit, and condiments. Bring pocket knife (no fork or spoon for survival), rope or paracord, sleeping bag & pad, camp clothing, flashlight, flint & steel kit, nalgene bottle, drinking water. NOTE: no cook kit. (Scouts may bring fork/spoon, plate, etc. for troop cook meals, but may not use them for the Wilderness Survival portion of the campout.)

**Itinerary:**    Meet at Mentor United Methodist Church on Friday 6:30 PM and return Sunday at approximately 10:30 AM in the K-Mart front parking lot.

**PLEASE PROVIDE CONTACT NUMBERS FOR SUNDAY MORNING.**

**Directions:**    Boyd family property - 7244 Leroy Thomson Road, Thomson, OH 44086  
Go to our web site [www.mentortroop280.com](http://www.mentortroop280.com) for map and directions.

**Contacts:**      Cell Phone number for Mr. McIntyre: 440-251-3590

# TROOP 280

## PERMISSION SLIP AND MEDICAL FORM

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Name of Parent/Guardian \_\_\_\_\_ Telephone \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

PHONE NUMBER FOR PICK-UP \_\_\_\_\_

**USE MEDICAL FORM ON FILE**     Yes     No

**IF NO FORM IS ON FILE OR CHANGES IN HEALTH EXIST, PLEASE COMPLETE BELOW**

Check all items that apply, past or present, to your health history. Explain any "Yes" answers.

Allergies: Food, Medicines, Insects, Plants, Animals, etc.    Yes     No

Explain: \_\_\_\_\_

General Information	Yes	No		Yes	No		Yes	No
Convulsions/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>			

List any medications to be taken at camp: \_\_\_\_\_

List any physical or behavioral conditions that may affect or limit full participation in swimming, backpacking, hiking long distances, or playing strenuous physical games: \_\_\_\_\_

List any equipment needed such as wheelchairs, braces, glasses, contact lenses, etc.: \_\_\_\_\_

Immunizations (Give date of last inoculation):

Tetanus toxoid \_\_\_\_\_ Pertussis \_\_\_\_\_ Mumps \_\_\_\_\_ Polio \_\_\_\_\_  
 Diphtheria \_\_\_\_\_ Measles \_\_\_\_\_ Rubella \_\_\_\_\_

**Name of Personal Physician** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Personal health/accident insurance carrier** \_\_\_\_\_ **Policy Number** \_\_\_\_\_

**Parent Authorization:**

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed activities, except as noted by me. In the event of illness or accident in the course of such activity, I request that measures be instituted without delay as the judgement of medical personnel dictates.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_