

TROOP 280

Activity/Outing: Boyd's Woods -- PLC / Advancement

Dates: Nov 14 – 15

THIS IS A BSA EVENT

Medical Forms are required for all attendees.

Meet: 8:00 AM -- Saturday, Nov. 14 at Mentor United Methodist Church

Return: Approx 10:00 AM – Sunday, Nov. 15 at K-Mart front Parking Lot

Cost: \$20.00 per Participant

Required Gear: Normal camping gear

Weather appropriate gear, Camp chair, Mess kit, Scout Handbook

Program: We will be tent camping at Boyd's property. Leadership positions will be planning the coming year's activities. Others will work on rank advancement requirements throughout the day on Saturday. Bring your Scout handbook for sign-off of completed requirements.

Itinerary: Meet at Mentor United Methodist Church on Saturday morning, drive to Boyd's property and set up tents. Saturday we will work on various rank requirements. We will return Sunday at approximately 10:00 AM, drop-off location is 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 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	___	___	Asthma	___	___	Heart Trouble	___	___
Cancer / Leukemia	___	___	Diabetes	___	___	Hemophilia	___	___
High Blood Pressure	___	___	Kidney Disease	___	___			

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** _____