

Boy Scouts of America Medical Treatment Authorization

Scout's Name	Home Phone	Birth Date
Father's Name	Mobile Phone	Work Phone
Mother's Name	Mobile Phone	Work Phone
Address		

Emergency Contact in the Event Parents are Unreachable

Name	Relationship		
Address			
Home Phone	Mobile Phone	Work Phone	Other Phone

Insurance Coverage

Employer	Insurance Carrier
HR Phone	Insurance Phone
Group Number	Policy Number
Other Information	

Authorization for Medical Treatment

In the event of a serious injury or illness that requires medical attention, and that I cannot be contacted, I authorize an adult leader of the Boy Scouts of America to admit my son, named above, to the nearest medical facility for diagnosis and treatment. I request and authorize appropriate medical personnel to perform diagnostic procedures, administer anesthetics, and perform treatment procedures, and operative procedures as may be necessary in the diagnosis and treatment of my son.

Parent/Guardian (Signed in the presence of a Notary) Date _____

State of Texas, _____ County.

Subscribed and sworn before me on this, the _____ day of _____, _____

In and for the State of Texas;

(Notary Signature)

Expires: _____