

**Boy Scout Troop 76**  
**Ridgefield, Connecticut**

**Participation Consent Form**

**Trip:** Destination BOSTON FREEDOM TRAIL  
**Date:** Date Friday March 19, 2010 to Sunday, March 21, 2010  
**Meet at:** Jesse Lee Parking Lot: Friday, March 19 at 6:30 PM  
**Pickup:** Jesse Lee Parking Lot: Sunday, March 21 at 5:30 PM

**DO NOT BE**  
**LATE!**

**In case of Emergency, contact Troop through:**  
ASM Laura Solomon cell: (203) 722-0951  
ASM Paul Tepfer home (203) 431-8706

*Dear Parent: This form is necessary and required for each and all troop activities. No individual will be permitted to attend this trip unless this form is signed and returned to Troop 76 prior to the departure for the trip. We will do everything reasonably within our power to provide for the safety of each participant. It is our intent to provide adequate adult supervision through the Troop leaders and parent volunteers that will attend this trip.*

**\* \* \* \* CUT TOP AND SAVE \* \* \* \***

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**Trip:** Boston Freedom Trail  
**Date:** Friday March 19, 2010 to Sunday, March 21, 2010

*In consideration of the benefits to be derived, and in view of the fact that the Boy Scouts of America is an educational, nonprofit institution, membership and participation in which is voluntary, and having full confidence that every reasonable precaution will be taken to ensure the safety of the participant named below on this activity, I hereby agree to his participation and waive all claims against the leaders of this trip, officers, agents, and representatives of the Boy Scouts of America, this Troop, and the sponsor.*

Scout Name: \_\_\_\_\_

Any condition now requiring medication?  No  Yes

Name of medication & dosage: \_\_\_\_\_

Any restriction of activity for medical reasons?  No  Yes

If Yes, explain in detail: \_\_\_\_\_

Special medical instructions (e.g. drug or food allergies): \_\_\_\_\_

\_\_\_\_\_

*In the event I cannot be reached in an emergency, or if an attending physician or health care provider believes immediate medical care is required without delay, I hereby give permission to the physician or health care provider, selected by the adult leader, to secure medical treatment, hospitalize, secure anesthesia, or to order injection or surgery for the participant named above, at my expense.*

Signature of Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_