Part - E

BSA Troop 1705

Troy, Michigan 48085

2016 – 2017 Scout Contact Information & Medical Treatment Authorization

Scout's Full Legal Name: _____

Birth Date: _____ Home Phone: _____

Street Address: _____

City: _____, MI Zip: _____

Father's Full Legal Name: _____

Work Phone: _____ Cellular #: _____

e-mail address: _____

Mother's Full Legal Name: _____

Work Phone: _____ Cellular #: _____

e-mail address: _____

Health Insurance Company: _____

Contract #: _____ Plan Code: _____

Group #: _____ Coverage Code: _____

Doctor: _____ Phone #: _____

In an emergency, I grant permission to the Adult Leaders of BSA Troop 1705 to secure emergency medical aid/treatment and or surgical treatment, and routine non-surgical medical care for the scout named above while participating in Boy Scout functions and activities. I also certify that the information on this form is correct to the best of my knowledge. I also guarantee payment for the treatment and services provided to my son.

This form is to cover the September 1, 2016 to September 30, 2017 Scouting Year.

_____ _____

Signature of Parent/Guardian Date

_____

Printed Name of Parent/Guardian

(Rev 09/06/16)