

**Troop 100**  
**Annual Permission Form**

I, \_\_\_\_\_ (parent/guardian), give my permission to Boy Scout Troop 100 for my son, \_\_\_\_\_ to participate in any Troop 100 activities (i.e. campouts, day outings, service projects, summer camp, etc.) for this year 201\_\_ to the next chartering period. I have furnished all up to date medical physicals, copies of my medical insurance cards, made note in writing of any disability or medication needing to be taken, and emergency numbers to Troop 100. I further allow the leaders of the activity to seek out medical treatment in case of emergency. I also understand that the leaders of the activity will contact me or my emergency contact at the soonest moment possible. I understand that scouting activities may be rigorous and that they may involve risk of serious injury. My son is in good physical condition and is fully able to participate in all prescribed activities. I have carefully considered the risks involved and agree to hold the Boy Scouts of America, Inc., Three Fires Council, BSA, BSA volunteers, and their respective officers, leaders, agents, representatives and employees harmless from all personal injury and illness arising out of, or resulting from, participation in such activities, including travel to and from such activities. I also understand that there will be a specific permission slip and medical form for any High Adventure programs through the Troop 100, Thunderbird District, or the Three Fires Council.

**Parent/Guardian signature and date:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Scout name and birthday:** \_\_\_\_\_ **Birthday:** \_\_\_\_\_

**Complete mailing Address:** \_\_\_\_\_

**Phone numbers including area codes. Indicate numbers for mother and father as appropriate.**

**Home:** \_\_\_\_\_

**Cell:** \_\_\_\_\_

**e-mails: (for Troop roster)** \_\_\_\_\_

**Boy's e-mail** \_\_\_\_\_ **Boy's cell phone** \_\_\_\_\_

**Please note: The Leader MUST (by BSA policy) carry all medications except inhalers and Bee Sting Kits.**

**My Scout carries:** \_\_\_\_\_ **Bee Sting Epi Pen** \_\_\_\_\_ **Inhaler** \_\_\_\_\_

**He knows how and when to apply or use. Circle: YES NO**

**He needs assistance with application. YES NO**

**Special note: Parents will be notified immediately upon application of Bee Sting Epi Pen.**

**Do you wish to be notified of Inhaler use? YES NO**

**Please describe any other prescribed medication needed by your scout. Include the medication dosage and instructions. Also indicate any specific allergies the scout has.**

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**Please circle the following medications to indicate that you give permission for the scout to take any of them if needed from the Troop leader or Camp Nurse.**

**Tylenol      Ibuprofen      Benedryl      Calamine Lotion      \_\_\_\_\_ (other)**