BSA Troop 209
CONSENT FORM
Approval by Parent or Guardian

Scouts First Name(s) Last Name Birth Date(s)

Street Address City State Zip

Has **MY CONSENT** to attend; **Hocking Hills Rappelling**
Name of Activity or Trip

On the following **DATES/TIMES;**

LEAVING- **Friday, August 24** at **4:30 PM** RETURNING- **Sunday August 26** at **11:30**

*unless otherwise noted ALL activities and trips will begin and end at the church parking lot.

TRIP COST: # of Scouts _____ x $ **36.00** incl camping, and food = $_____

# of Adults _____ x $ **26.00** including camping, and food = $_____

Total Remitted = $_____

**Scouts & Adults responsible for brown bag dinner on Friday evening.

PAID BY; Please Select One - Check _____ Cash _____Mulch_____

TRANSPORTATION; I can____ **OR** I cannot_____ drive to ____ from ____both ways_____.

In doing so I can take _____ Scouts in my _____ (type of vehicle).

Hold Harmless Agreement

I understand that participation in Scouting activities involves a certain degree of risk and can be physically, mentally, and emotionally demanding. I have carefully considered the risk involved and have given consent for myself or my child to participate in this activity. I also understand that participation in this activity is entirely voluntary and requires participants to abide by applicable rules and standards of conduct. I release the Boy Scouts of America, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with the activity from any and all claims or liability arising out of this participation.

In case of emergency involving my child, I understand every effort will be made to contact me. In the event I cannot be reached, I hereby give my permission to the medical provider selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child. Medical providers are authorized to disclose to the adult in charge examination findings, test results, and treatment provided for purposes of medical evaluation of the participant, follow-up and communication with the participant's parents or guardian, and/or determination of the participant's ability to continue in the program activities.

Please Print Scouts Name_____

Parent/Guardian Signature_____Date_____

Parent/Guardian Phone (____) _____Cell (____)_____

Revised 2/24/14