

Troop 332 Campout Permission Slip

Comments (use back for more room):

Event: Philmont Practice Hike - January

Event Date: January 18-19

Form Due: Monday, January 13th

Where: Hocking Hills State Park Campground, Group Site G-3 (Behind the Swimming Pool)
19852 OH-664, Logan, OH 43138 740-385-6841

When: Meet at the church at 6:15 AM Saturday morning; returning afternoon on Sunday.
A few of us will be going down Friday night & you are welcome to join us.

Overnight practice hike for Philmont. We'll be meeting at the church at 6:15 am on Saturday morning. The plan is to leave the group campsite at 8:30 and hike down to the Hocking Hills Winter Hike starting point. This will be a 6 mile hike. We will stop at Cedar Falls for lunch. The Kiwanis serves bean soup (free or w/donations). We will then continue on to Ash Cave. We will return to the starting point via provided buses. On Sunday morning we will hike to Whispering Cave and up to where the old SP Lodge was. We will then return to camp. This is about a 5 mile hike. I estimate that we will return to Columbus at around 2:00 PM.

The cost of the trip will be for food and camping. Estimated ~\$12. To be paid to purchaser of food, not to troop

Attendees (write on back if needed)

Name	Patrol
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

	QTY	Price	Total (Qty x Price)
Scout (Youth) Camper		\$12	
Adult Camper		\$12	
How are you paying? <input type="checkbox"/> Cash <input type="checkbox"/> Check		Total \$	

AUTHORIZATION FOR MEDICAL ATTENTION

In case of an emergency involving my child, I understand every effort will be made to contact me. In the event I cannot be reached, I hereby authorize the adult leader in charge to act on my behalf and in my stead in obtaining any medical or dental treatment for the above named scout(s) should said treatment become necessary in the opinion of the adult scout leader in charge and I 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. I hereby release the scout leader and the treating Physician, Dentist, or Health care provider of rendering any emergency medical treatment during the duration of the above outing.

Physical Restrictions? _____ Allergies? _____

Medications? _____

Phone _____ Home Address _____

Another person to contact in case of emergency _____

(NAME & NUMBER)

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 my child and myself (if applicable) 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.

(PARENT OR GUARDIAN SIGNATURE)

(DATE)
