



Boy Scouts of America  
Troop 1094  
Guardian Angels

**Scout  
Medication  
Treatment  
Authorization**

Scout's Full Legal Name:					
Birth Date:		Home Phone:			
Address:					
City:		State:		Zip:	

**Contact Information:**

Father's Full Legal Name:					
Work Phone:		Cell Phone:			
Mother's Full Legal Name:					
Work Phone:		Cell Phone:			
Health Insurance Company:					
Contract#:		Plan Code:			
Group#:		Coverage Code:			
Comments:					

**Physician:**

Name:		Phone #:			
Address:		City:		Zip:	

In an emergency, I grant permission to the Adult Leaders of BSA Troop 1094 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 August 2004 to August 2005 Scouting year.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date