



Consent to Treat for a Minor and Activity Authorization

Old Baldy Council BSA 1047 West 6th Street, Ontario, CA. 91762

Name of Minor _____ Unit # _____
Date of Birth _____ Council _____

Authorization to Treat: The undersigned do hereby authorize the Boy Scouts of America, or such substitute as designated as agent for the undersigned to consent to any x-ray examinations, anesthetic, medical, dental, or surgical diagnosis or treatment and hospital care for the minor which is deemed advisable by and to be rendered under general or special supervision of any physician or surgeon licensed under the Provision of Medicine Act or any dentist licensed under the Dental Practice Act, whether such diagnosis or treatment is rendered at the office of the physician or dentist, hospital, Scout camp, or elsewhere.

Activity Authorization: Please **initial** either **yes or no** for each activity below. Marking **yes** will give your child permission to participate in that activity. Failure to mark either box, or changes to this form will result in your child not participating in the activity.

Yes _____ No _____ Authorization to participate in **ARCHERY**

Yes _____ No _____ Authorization to participate in **SHOOTING SPORTS**
(This includes 22-rifle, Shotgun, Black Powder, and BB guns)

Yes _____ No _____ Authorization to participate in **CLIMBING/RAPPELLING**

Yes _____ No _____ Authorization to participate in **HORSEBACK RIDING**
(This includes all wrangler activities at Hitchcock Ranch, and Trail Rides.)

Yes _____ No _____ Authorization to participate in **WATER SPORTS/ACTIVITIES**
(This includes all activities and sports occurring at the pool and lake facilities)

- This authorization will remain in effect while the minor is in route to or from this Scouting activity and/or any other activities held in connection.

Date: _____ Father/Legal Guardian Signature: _____

Mother/Legal Guardian Signature: _____

Street Address: _____ City _____ State _____ Zip _____

Home Phone: () _____ Work Phone: () _____

Cell Phone: () _____ Other: () _____

Insurance information: _____ Policy #: _____

Medical Doctor: _____ Phone #: () _____

Know Allergies: _____ Current Medications: _____

Update Annually