Ventura County Council BSA (Boy Scouts)
Consent to Treat for a Minor and Activity Authorization

Pursuant to California Family Code Section 6910 – For Treatment
Pursuant to California Civil Code 56.11 – For release of Medical Information

Name of Minor _____ ***Unit #*** _____

Date of Birth _____ ***Council*** _____

The undersigned does hereby authorize: _____
(Print name of unit leader)
or such substitute as designated as agent for the undersigned to consent to any x-ray, examination, 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 **Mountain Biking**

Yes_____ No_____ Authorization to participate in **Shooting Sports**
(Includes 22-rifle, Shotgun, Black Powder, BB guns, and Archery)

Yes_____ No_____ Authorization to participate in **Climbing/Rappelling**

Yes_____ No_____ Authorization to participate in **Water Sports / Activities**
(Includes all activities and sports occurring at Pool and Lake)

This authorization will remain in effect while the minor is in route to or from this Scouting activity at Camp Three Falls and/or any activity held in connection with Camp Three Falls

Father/Legal Guardian Signature: _____ Date:_____

Mother/Legal Guardian Signature:_____ Date:_____

Street Address_____ City_____ State _____ Zip _____

Father Home Phone (___) _____ Work Phone (___) _____ Cell Phone (___) _____

Mother Home Phone (___) _____ Work Phone (___) _____ Cell Phone (___) _____

Medical Insurance Information:

Company or provider:_____ Policy Number _____

In Case of Emergency please notify:

Name (print) _____ Phone (____) _____

Physician: (print) _____ Phone (____) _____