

**PARENT/GUARDIAN CONSENT FORM FOR THE TREATMENT OF A MINOR**

I \_\_\_\_\_ (parent/guardian) being legal guardian of \_\_\_\_\_ (youth) authorize \_\_\_\_\_ (leader) or another adult registered with \_\_\_\_\_ (unit) to consent to in my absence and absent of other legal guardian, an X-ray, examination, anesthetic, medical or surgical diagnosis or treatment and hospital care to be rendered to the minor at a recognized medical facility under the general or special supervision of a licensed physician.

\_\_\_\_\_ (youth) has my permission to take part in activities with \_\_\_\_\_ (unit) in attending the Daniel Webster Council 2003 NH Jamboree to be held at Gunstock Recreation Area on October 3-5, 2003. We agree to hold harmless the Daniel Webster Council, Gunstock Recreation Area, and volunteers for injuries resulting from participating in the 2003 NH Jamboree.

Remarks \_\_\_\_\_

**Health History – For All Participants**

PLEASE PRINT

Name \_\_\_\_\_ Age \_\_\_\_\_

Unit # \_\_\_\_\_ District \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Health/accident insurance co. \_\_\_\_\_ Policy Number \_\_\_\_\_

Have or subject to (check if yes):

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Asthma   | <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Convulsions  |
| <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Heart trouble   | <input type="checkbox"/> Bleeding disorders   |
| <input type="checkbox"/> Allergy to any medication, food<br>plant, animal or insect toxin |  | <input type="checkbox"/> Any condition that may require<br>special care, medication or diet |

Explain \_\_\_\_\_

Check here if none of the above apply

Takes the following medications: \_\_\_\_\_

Have difficulty with (check if yes):  Eyes, ears, nose, throat  Digestion  Bed-wetting  Lungs  Sleep walking

Any restriction of activity for medical reasons? Explain? \_\_\_\_\_

<b>Immunizations</b>	<b><u>Date of last inoculation</u></b>	<b><u>Date of last inoculation</u></b>	<b><u>Date of last inoculation</u></b>	<b><u>Date of last inoculation</u></b>
Tetanus Toxoid	_____	Polio _____	Mumps _____	Pertussis _____
Diphtheria	_____	Measles _____	Rubella _____	

*This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed activities, except as noted by me.*

Signature \_\_\_\_\_ Date \_\_\_\_\_

(Parent/Guardian)

Home telephone # \_\_\_\_\_

Cell # \_\_\_\_\_

Work telephone # \_\_\_\_\_