EMERGENCY MEDICAL AUTHORIZATION
BOY SCOUTS OF AMERICA

_______________ *Scout Name*	_______________ *Telephone Number*
_______________ *Street Address*	_______________ *School Attending*
_______________ *City/State/Zip*	

The purpose of this form is to enable parents to authorize emergency treatment for children who become ill or injured while under the authority of the Boy Scouts of America, and when parents cannot be reached.

In the event reasonable attempts to contact me at _______________ (*Phone Number*) or _______________ (*Other Parent*) have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by Dr. _______________ (*Preferred Physician*) or Dr. _______________ (*Preferred Dentist*), or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and the transfer of the child to _______________ (*Preferred Hospital*) or any hospital reasonably accessible.

Our health insurance member numbers appear below for such use. All additional costs not covered by this insurance, or any other insurance in force, shall be paid upon our receipt of a bill for services rendered.

THIS AUTHORIZATION DOES NOT PERTAIN TO ANY SURGICAL PROCEDURE WHERE LIFE IS NOT THREATENED. If injury is life threatening, this authorization allows major surgery if the medical opinions of two other physicians or dentists, concurring in the necessity for such surgery, are obtained before such surgery is performed. Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

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Type of Insurance -

Group #

Certificate #

Other Medical Insurance

Type -

Number -

____
Father

____
Mother

____
Date Signed