LITHUANIAN SCOUTS ASSOCIATION

Pacific Region

paukštytė/vilkiukas_____
skautė/skautas_____
patyr-usi/ęs_____
vyr.sk./sk.vytis_____

Authorization and Consent to Emergency Medical Treatment of Minor

(Pursuant to Calif. Civil Code Section 25.8 and Calif. Penal Code Section 12552)

Name of Minor:_____**Soc.Sec.#**_____**Troop/Tuntas**_____

Address_____**City**_____**State**_____**Zip**_____

Telephone_____**Date of Birth**_____**Age**_____

Family Medical Insurance Co._____**Policy #**_____

Address of Ins. Co._____Phone #_____

Please attach photocopy of insurance card. If family has no insurance, state "NONE".

In Case of Emergency, Notify:

Name_____Relationship_____Home Phone_____

Address_____Bus. Phone_____

Alternate Contact_____Relationship_____Phone_____

The undersigned hereby authorizes the Scoutmaster of the Troop, or such substitute as he/she may designate 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 above minor which is deemed advisable by and to be rendered under the general or special supervision of any physician and/or surgeon, licensed under the provision of the Medicine Practice Act or any dentist licensed under the Dental Practice Act, whether such diagnosis of treatment is rendered at the office of said physician or dentist, at a hospital, scout camp, or elsewhere. This authorization will remain effective while the above minor is en route to or from, or involved participating in, any scout program activity of the Lithuanian Scouts Association, Pacific Region, unless revoked in writing by the undersigned and delivered to the aforesaid agent.

Participant Medical History. Are you now, or have you ever been treated for any of the following? (answer "yes" or "no")

Asthma_____Sinus trouble_____Fainting spells_____Convulsions_____Diabetes_____Heart trouble_____Bleeding disorders_____

Kidney disease_____Earaches/infections_____Abdominal problems_____Rheumatic fever_____Hay fever_____

Tuberculosis_____Epilepsy_____Frequent diarrhea_____Allergy to medication, food, plant *explain below*)_____Any condition requiring regular medication(*explain below*)_____Any other special conditions (*explain below*)_____

_____

_____

_____

Allergies or reactions to any medication_____**Allergy to bee or wasp stings**_____

Have you had more than a brief minor illness (*24 hrs. or more*), injury, or emotional difficulty during the past year?_____ If so, what?_____ Operations or serious injuries or hospitalization (*for any reason*) within past 36 months (*dates*)_____ **Any Restriction of activity for medical reasons?**_____**Explain**_____

Immunization dates: Tetanus toxoid:_____Polio:_____Mumps_____Pertussis:___ ___Diphtheria:_____Measles:_____Rubella_____

List Current medications and dosages below. All prescription medication must be in its original container with the original label.

Medication, dosage_____

I do hereby give permission to the medical staff at Camp Rambynas to administer these prescription medications as stated on this form.

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Father/Guardian Name_____**Signature**_____**Date**_____

Home phone_____**Work phone**_____

Mother/Guardian Name_____**Signature**_____**Date**_____

Home phone_____**Work phone**_____

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