

**TROOP 860 - BOY SCOUTS OF AMERICA
WAIVER OF LIABILITY & ASSUMPTION OF RISK
FOR PARTICIPATION BY AN ADULT IN SCOUT ACTIVITIES**

NAME: _____ YEAR: 01-01-20____ - 12-31-20____

IN CONSIDERATION FOR ALLOWING ME TO PARTICIPATE IN SCOUT ACTIVITIES, I WAVE, RELEASE, HOLD HARMLESS AND INDEMNIFY THE BOY SCOUTS OF AMERICA, THE MEMBERS OF TROOP 860 COMMITTEE, THE SCOUT MASTER AND HIS ASSISTANTS FROM ANY LIABILITY IN CONNECTION WITH MY ATTENDANCE AT, AND ENGAGEMENT IN, THESE ACTIVITIES, FROM ANY CLAIM OR LEGAL ACTION ARISING OUT OF INJURY OR PROPERTY LOSS SUSTAINED, WHETHER NEGLIGENTLY CAUSED OR OTHERWISE, IN CONNECTION WITH MY PARTICIPATION IN THESE ACTIVITIES. THIS RELEASE AND WAIVER INCLUDES INJURIES WHICH MAY BE INCURRED DURING TRANSPORTATION TO AND FROM SCOUT ACTIVITIES. I UNDERSTAND THAT RISK OF INJURY IS INHERENT IN SCOUT ACTIVITIES, AND I ASSUME ALL RISKS AND HAZARDS INCIDENTAL TO MY PARTICIPATION. I HEREBY REQUEST PERMISSION TO PARTICIPATE IN ANY AND ALL TROOP 860 APPROVED ACTIVITIES FOR THE ABOVE INDICATED PERIOD.

CONSENT FOR EMERGENCY MEDICAL TREATMENT

THE UNDERSIGNED HEREBY GIVES PERMISSION TO THE OFFICERS, LEADERS, EMPLOYEES OR AGENTS OF THE BOY SCOUTS OF AMERICA, THE LOS ANGELES AREA COUNCIL AND ADULT LEADERS OF TROOP 860, TO OBTAIN AND ADMINISTER SUCH MEDICAL OR DENTAL AID OR ASSISTANCE AS MAY BE REQUIRED FOR MY IMMEDIATE CARE IN THE EVENT THAT SUCH HELP BECOMES NECESSARY AND I AM UNABLE TO GIVE SUCH PERMISSION. IT IS FURTHER UNDERSTOOD THAT SUCH PERMISSION INCLUDES, WITHOUT LIMITATION, THE AUTHORIZATION OF THE UNDERSIGNED TO EACH OF THE OFFICERS, LEADERS, EMPLOYEES OR AGENTS OF THE BOY SCOUTS OF AMERICA, THE LOS ANGELES AREA COUNCIL AND THE ADULT LEADERS OF TROOP 860, TO CONSENT TO THE ADMINISTRATION OF SUCH MEDICAL OR DENTAL CARE TO ME IN THE EVENT THAT I AM UNABLE TO CONSENT TO SUCH CARE. IN NO EVENT SHALL THE BOY SCOUTS OF AMERICA, THE LOS ANGELES AREA COUNCIL, ITS OFFICERS, LEADERS OR AGENTS, BE HELD LIABLE FOR ANY FIRST AID OR MEDICAL OR DENTAL TREATMENT RENDERED OR CONSENTED TO DRUGS AND MEDICINE GIVEN OR CONSENTED TO BE GIVEN, OR SURGICAL PROCEDURES PERFORMED OR CONSENTED TO BE PERFORMED, PURSUANT TO THIS CONSENT.

A COPY OF THIS FORM MAY BE USED AS AN ORIGINAL

DATE: _____ SIGNATURE: _____
HOME PHONE: _____ CELL/WORK PHONE: _____

LIST SPECIAL INSTRUCTIONS, E.G., ALLERGIES, MEDICINES TO BE TAKEN: _____

MOST RECENT TETANUS SHOT: _____

HEALTH PLAN NO: _____ HEALTH PLAN: _____

(PLEASE ATTACH A COPY OF HEALTH PLAN CARD)

PHYSICIAN: _____

PHYSICIAN'S PHONE: _____

DATE: _____

WTNESS: _____ DATE: _____