



1047 West 6th Street, Ontario, CA 91762

CONSENT TO TREAT A MINOR

Name of Minor _____ Unit # _____

Date of Birth _____ Council _____

Authorization to Treat: The undersigned do hereby authorize the Boy Scouts of America, or such substitute as designated as agent for the undersigned to consent to any x-ray examinations, 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 at any physician or surgeon licensed under the Provision of Medicine Act Of any dentist licensed under the Dental Practice Act, whether such diagnosis or treatments 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 **SHOOTING SPORTS**
(This includes 22-rifle, Shotgun, Black Powder, and BB guns, Archery)

DATE _____ FATHER OR GUARDIAN: _____

signature

MOTHER OR GUARDIAN: _____

signature

WITNESS: _____

signature

HOME ADDRESS: _____

HOME PHONE: _____ BUSINESS PHONE: _____

DOCTOR'S NAME: _____ DOCTOR'S PHONE: _____

INSURANCE CARRIER: _____ POLICY: _____

IMPORTANT MEDICAL INFORMATION (ALLERGIES, MEDICATION, ETC.): _____

*Pursuant of California Civil Code Section 25.8
Pursuant to California Penal Code Section 12552*