Ship 5052 Annual Participation Release & Consent to Treat a Minor

Name of Minor: _____ ***Date of Birth:***_____

Program Year: _____

Sea Scout _____ will be participating in supervised Sea Scout activities involving physical activity such as cruising, rowing, sailing, and swimming and various maintenance chores that keep boats and equipment operating safely and efficiently. As with any physical activity, there is risk. The named Sea Scout's participation is done so freely, upon his/her own initiative, risk and responsibility.

In the event of injury, illness, or death, the undersigned parent/guardian of the minor expressly releases and forever discharges the Northland Nautical Foundation, its officers and board members, Ship 5052, the Boy Scouts of America, their employees, Scout leaders, Local, Area, Regional or National Council, their officers and agents, acting officially or otherwise from all claims, demands, actions, or causes of action that may occur during Sea Scout activities.

Parent/Guardian/Sea Scout over 18 Signature: _____ ***Date:*** _____

Authorization & Consent to Treat a Minor

The undersigned do hereby authorize (name of leader) _____ , or such substitute as may be designated as their agent for the Sea Scout, 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 rendered under the general or special supervision of any physician and surgeon, licensed under the Provision of Medicine Practice Act or of any dentist licensed under the Dental Practice Act, whether such diagnosis or treatment is rendered at the office of said physician or dentist, at a hospital, Sea Scout event, or elsewhere.

The authorization will remain in effect while the above minor is enroute to or from or involved in any Sea Scout activity, unless revoked in writing by the undersigned, and delivered to the aforesaid agent.

Parent/Guardian/Sea Scout over 18 Signature: _____ ***Date:*** _____

Address: _____ _____

Home Phone: _____ ***Business Phone:*** _____ ***Mobile:*** _____

Witness: _____

Primary Health Care Provider Policy Number: _____

Allergies: _____

Current Medications: _____

Physical Limitations: _____