

Rendezvous Number:

ADULT TRIP RELEASE

Ship Name: _____

2009

Ship Number: _____

SOUTHWESTERN RENDEZVOUS

November 22th, 28th and 29th

WHEREAS I, _____ (PRINT FULL NAME), am an Adult in the Boy Scouts of America and as such am scheduled aboard the Port Hueneme, Ventura, California, for the Rendezvous Competition, I expect to participate in this experience as a part of my Scout program. AND WHEREAS, I am doing so as a volunteer and entirely upon my own initiative, risk and responsibility; NOW THEREFORE, in consideration of such recognition and of the permission extended to me by the U.S. Navy or other owners or operators of said Base, I do hereby for myself, my heirs, executors and administrators relieve, release and forever discharge the government or the United States of America and all its officers, employees and agents, the Boy Scouts of America, their employees, the local council and National Council, local Scout unit, chartered institution, and all Scouts and Scout leaders, their officers and agents, acting officially or otherwise, from any and all claims, demands, actions or causes of action on account of my death or on account of any injury to me which may occur by reason of the above activity.

Signature of Participant

OPTIONAL: HEALTH HISTORY AND MEDICAL CONSENT

PARTICIPANT: _____ (PRINT FULL NAME)

HAS OR SUBJECT TO: (CHECK IF YES)

<input type="checkbox"/> asthma	<input type="checkbox"/> fainting spells	<input type="checkbox"/> convulsions	<input type="checkbox"/> reactions to any medications
<input type="checkbox"/> diabetes	<input type="checkbox"/> heart trouble	<input type="checkbox"/> allergies	<input type="checkbox"/> swimming or sports restrictions
<input type="checkbox"/> other			

Describe:

Check here if none of the above applies

HAS DIFFICULTY WITH: (CHECK IF YES)

<input type="checkbox"/> eyes, ears, nose, throat	<input type="checkbox"/> digestion	<input type="checkbox"/> bedwetting
<input type="checkbox"/> lungs	<input type="checkbox"/> sleepwalking	<input type="checkbox"/> other

HAS HAD OR BEEN IMMUNIZED FOR: (CHECK IF YES)

<input type="checkbox"/> mumps	<input type="checkbox"/> chicken pox	<input type="checkbox"/> whooping cough
<input type="checkbox"/> measles	<input type="checkbox"/> German measles	<input type="checkbox"/> diphtheria

Any condition now requiring medication? _____ Name of medication(s): _____

Any restriction of activity for medical reasons? YES NO (if YES, explain) _____

PARENT AUTHORIZATION

This health history is correct so far as I know. In the event of an emergency, I hereby give permission to the physician, selected by the adult leader in charge, to hospitalize, secure proper anaesthesia, or to order injections for myself.

Signature: _____
Adult Attendee

Date: _____

Signature: _____
Unit Leader

Date: _____