



**LONG BEACH AREA COUNCIL**  
**Boy Scouts of America**



Sea Scout Ship  
**Conquest**  
 Long Beach, CA

**INFORMED CONSENT AGREEMENT**

I, the parent/guardian of \_\_\_\_\_, a minor and member of *S.S.S. Conquest*, Ship 564, hereby grant approval for him/her to participate in the Camp, Trip, or Cruise, as described below. Said minor is amenable to such rules and regulations as may be made by the Long Beach Area Council Executive Board or its representatives.

It is expressly understood by the parents or guardian that the Scout for whom this application is made is in a condition of health that warrants his/her taking part in this event, and that the leader of this outing is hereby granted permission to take the named Scout to a medical doctor for examination and treatment of any accident or illness that may arise during the term of said outing. (See authorization below).

**HOLD HARMLESS AGREEMENT**

I understand that participation in the activity involves a certain degree of risk. I have carefully considered the risk involved and have given consent for myself or my child to participate in the activity. I understand that participation in the activity is entirely voluntary and requires participants to abide by applicable rules and standards of conduct. I release the Boy Scouts of America, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with the activity from any and all claims or liability arising out of this participation.

**AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR**

In case of emergency, I understand every effort will be made to contact me. In the event I cannot be reached, the undersigned hereby authorize the Scouting Leader as agent for the undersigned to consent to any X-ray examination, anesthetic medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the Medicine Practice Act on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care that the aforementioned physician in the exercise of his best judgment may deem advisable.

**THIS AGREEMENT IS IN EFFECT FOR THE FOLLOWING EVENT**

**Place:** \_\_\_\_\_ **Dates:** From: \_\_\_\_\_ To: \_\_\_\_\_

**Signed:** \_\_\_\_\_ **Print:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
 (Parent or Guardian) (Please print your name)

**Emergency Phone Number(s) Where Parent/Guardian May Be Contacted:** \_\_\_\_\_

**Emergency Name(s) & Phone Number(s) in the event that Parent/Guardian Cannot Be Contacted:** \_\_\_\_\_