

**EMERGENCY MEDICAL AUTHORIZATION  
CUB SCOUT PACK 275**

In the event reasonable attempts to contact me at \_\_\_\_\_ (telephone number)

Or \_\_\_\_\_ (name of other parent/guardian) at \_\_\_\_\_  
(telephone number) have been unsuccessful.

I \_\_\_\_\_ (name), the parent (guardian or custodian) of  
\_\_\_\_\_ (name of Scout), a minor at the following  
address \_\_\_\_\_ hereby authorize and consent to (1) the  
administration of any treatment deemed necessary by (physicians and/or dentists names below)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

or in the event the designated preferred practitioner is not available, by another licensed physician and/or dentist; and  
(2) transfer the minor to the nearest hospital.

This authorization does not cover major surgery unless the medical opinions of two-licensed physician (or  
dentist, if applicable), concurring in the necessity for such surgery, are obtained before surgery is performed.

Facts concerning the minor's medical history including allergies, medications being taken and any physical  
impairment to which a physician should be alerted:

- (1) \_\_\_\_\_  
(2) \_\_\_\_\_  
(3) \_\_\_\_\_

\_\_\_\_\_  
(Signature of parent/guardian & date)

\_\_\_\_\_  
(address)

\_\_\_\_\_  
(telephone number where you can be reached)

Signed in my presence on this \_\_\_\_ day of \_\_\_\_ 20 \_\_\_\_

By \_\_\_\_\_

\_\_\_\_\_  
Notary Public

My Commission Expires: \_\_\_\_\_