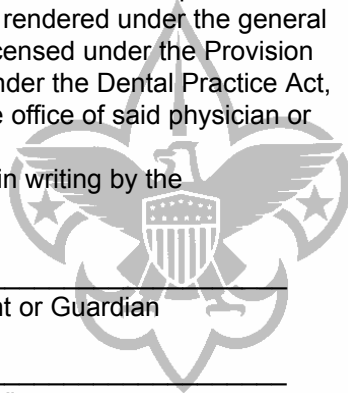


**Authorization and Consent to Minor**  
Pursuant to California Civil Code Section 25.8

MINOR \_\_\_\_\_ D.O.B \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

The undersigned do hereby authorize any adult representative of Boy Scout, Troop 2222 as agent for the undersigned 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 and to be rendered under the general or special supervision of any physician and surgeon licensed under the Provision of the Medicine Practice Act, or 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, or elsewhere.  
This authorization will remain in effect unless revoked in writing by the undersigned and delivered to the aforesaid agent.

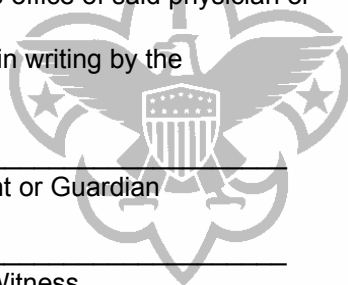


\_\_\_\_\_  
Date Parent or Guardian  
\_\_\_\_\_  
Date Witness

**Authorization and Consent to Minor**  
Pursuant to California Civil Code Section 25.8

MINOR \_\_\_\_\_ D.O.B \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

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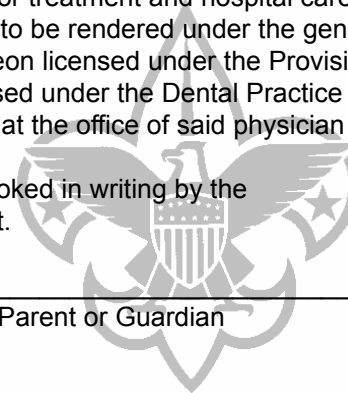


\_\_\_\_\_  
Date Parent or Guardian  
\_\_\_\_\_  
Date Witness

**Authorization and Consent to Minor**  
Pursuant to California Civil Code Section 25.8

MINOR \_\_\_\_\_ D.O.B \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
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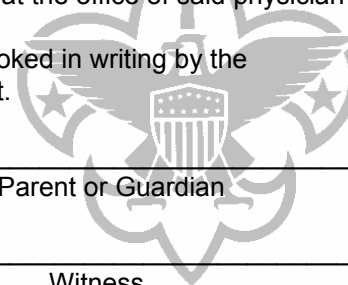


\_\_\_\_\_  
Date Parent or Guardian  
\_\_\_\_\_  
Date Witness

**Authorization and Consent to Minor**  
Pursuant to California Civil Code Section 25.8

MINOR \_\_\_\_\_ D.O.B \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
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\_\_\_\_\_  
Date Parent or Guardian  
\_\_\_\_\_  
Date Witness

### Emergency Medical Information

MINOR \_\_\_\_\_ DOB \_\_\_\_\_  
BLOOD TYPE \_\_\_\_\_ WEIGHT \_\_\_\_\_  
IMMUNIZATIONS CURRENT? YES / NO LAST TETANUS \_\_\_\_\_  
HANDICAPS / DISABILITIES / APPLIANCES: \_\_\_\_\_

MEDICAL HISTORY: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

CURRENT PRESCRIBED MEDICATIONS: \_\_\_\_\_

ALLERGIES TO MEDICATION: \_\_\_\_\_

OTHER ALLERGIES: \_\_\_\_\_

INSURANCE CARRIER: \_\_\_\_\_

ACCOUNT NUMBER: \_\_\_\_\_

PRIMARY CARE DOCTOR \_\_\_\_\_

PHONE NUMBER FOR DOCTOR \_\_\_\_\_

OTHER CONTACT PERSON:

NAME: \_\_\_\_\_ PHONE \_\_\_\_\_

### Emergency Medical Information

MINOR \_\_\_\_\_ DOB \_\_\_\_\_  
BLOOD TYPE \_\_\_\_\_ WEIGHT \_\_\_\_\_  
IMMUNIZATIONS CURRENT? YES / NO LAST TETANUS \_\_\_\_\_  
HANDICAPS / DISABILITIES / APPLIANCES: \_\_\_\_\_

MEDICAL HISTORY: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

CURRENT PRESCRIBED MEDICATIONS: \_\_\_\_\_

ALLERGIES TO MEDICATION: \_\_\_\_\_

OTHER ALLERGIES: \_\_\_\_\_

INSURANCE CARRIER: \_\_\_\_\_

ACCOUNT NUMBER: \_\_\_\_\_

PRIMARY CARE DOCTOR \_\_\_\_\_

PHONE NUMBER FOR DOCTOR \_\_\_\_\_

OTHER CONTACT PERSON:

NAME: \_\_\_\_\_ PHONE \_\_\_\_\_

### Emergency Medical Information

MINOR \_\_\_\_\_ DOB \_\_\_\_\_  
BLOOD TYPE \_\_\_\_\_ WEIGHT \_\_\_\_\_  
IMMUNIZATIONS CURRENT? YES / NO LAST TETANUS \_\_\_\_\_  
HANDICAPS / DISABILITIES / APPLIANCES: \_\_\_\_\_

MEDICAL HISTORY: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

CURRENT PRESCRIBED MEDICATIONS: \_\_\_\_\_

ALLERGIES TO MEDICATION: \_\_\_\_\_

OTHER ALLERGIES: \_\_\_\_\_

INSURANCE CARRIER: \_\_\_\_\_

ACCOUNT NUMBER: \_\_\_\_\_

PRIMARY CARE DOCTOR \_\_\_\_\_

PHONE NUMBER FOR DOCTOR \_\_\_\_\_

OTHER CONTACT PERSON:

NAME: \_\_\_\_\_ PHONE \_\_\_\_\_

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MINOR \_\_\_\_\_ DOB \_\_\_\_\_  
BLOOD TYPE \_\_\_\_\_ WEIGHT \_\_\_\_\_  
IMMUNIZATIONS CURRENT? YES / NO LAST TETANUS \_\_\_\_\_  
HANDICAPS / DISABILITIES / APPLIANCES: \_\_\_\_\_

MEDICAL HISTORY: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

CURRENT PRESCRIBED MEDICATIONS: \_\_\_\_\_

ALLERGIES TO MEDICATION: \_\_\_\_\_

OTHER ALLERGIES: \_\_\_\_\_

INSURANCE CARRIER: \_\_\_\_\_

ACCOUNT NUMBER: \_\_\_\_\_

PRIMARY CARE DOCTOR \_\_\_\_\_

PHONE NUMBER FOR DOCTOR \_\_\_\_\_

OTHER CONTACT PERSON:

NAME: \_\_\_\_\_ PHONE \_\_\_\_\_