PERMISSION SLIP (Parents keep this part) **TROOP 583**

BEAR CREEK CAMPOUT MARCH 18-20, 2016

Your signature is required in order that your son may participate in the following activity. If you will attend please check ADULT. If you will drive please include TOTAL NUMBER OF SEATBELTS. You may be able to take the mileage off of your taxes.

WHAT: Bear Creek Campout
Leave: Meet at Peace Lutheran Friday Mar 18, 2016 Time: 6:00 PM
Return: Meet at Peace Lutheran Sunday Mar 20, 2016 Time: 11:00 AM
Purpose: Fun and New Scout Camping
Permission slip due**: Tuesday Mar 8, 2016**
Emergency call: Midori Raymore (720) 490-8231
(This is the contact person in Denver.)
Scout In-Charge contact: Liam McCarthy
Adult In-Charge contact: Ruben Padilla (303) 526-6130

Activity Cost: Scout: $10
Adult: $10
Food Cost: $10

TOTAL: $20 per Scout / Adult

Patrol Equipment List:
Stoves, tents, Chuck Box, tarps, Grill, Water, lanterns, propane, firewood, wood

Individual Equipment:
Winder clothing, sleeping clothes, winter coat, gloves, stocking cap, Day Pack essentials, cot, sleeping bag, lots of wool socks, and wood blanket.

Special Instructions and Essentials:

***** NEED MEDICAL FORMS A & B *****

PERMISSION SLIP (Scoutmaster carries this part) **TROOP 583**
SLIP MUST BE TURNED IN BY THE DATE NOTED

WHAT: BEAR CREEK CAMPOUT

Leave: Meet at Peace Lutheran Friday Mar 18, 2016 Time: 6:00 PM
Return: Meet at Peach Lutheran Sunday Mar 20, 2016 Time: 11:00 AM
Drive: ( ) No ( ) Yes, total number of seat belts _____

PARENT NAME: _____ PHONE: _____
Adult Attending ( ) Yes ( ) No

SCOUT NAME: _____ PATROL: _____

ADDRESS: _____

By signing below I acknowledge that some dangers are inherent in every activity including this one. I give my permission for my son to participate in the above activity.

SIGNATURE: _____
If you do not wish your son's picture to appear in the troop web site check here. [ ]

In case of emergency, I understand that every effort will be made to notify me. In the event I cannot be reached, I give permission to the physician selected by the leader to hospitalize and secure proper treatment, including surgery for my son.

SIGNATURE: _____ DATE: _____

DOCTOR'S NAME: _____ PHONE: _____

PRIMARY INSURANCE COMPANY _____

POLICY NUMBER _____

Please list any medication, prescription drugs, allergies, or dietary conditions, which should be known by the leader.