

HUNGTEETSEPOPPI LODGE #466
PIEDMONT COUNCIL, BSA
POPPIFEST RESERVATION
March 10-12th, 2006 AT CAMP AUGUSTA

NAME _____
PHONE # _____ UNIT _____
ADDRESS _____
CITY _____ ZIP _____
EMAIL ADDRESS _____
DATE OF BIRTH _____ I CAN DRIVE _____ BROTHERS
AMOUNT ENCLOSED _____ (\$18.00 FOR MEMBERS, **DUE 3/1/06**)
SEND TO: POPPIFEST, PIDMONT COUNCIL, BSA, 10 HIGHLAND WAY, PIEDMONT, CA, 94563

AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR

(I) (We), the undersigned parent(s) of _____, a minor, do hereby authorize the Officers or Representative(s) of the Piedmont Council Boy Scouts of America, as agent(s) 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 being 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 * _____ 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 being required but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all diagnosis, treatment, or hospital care which the aforementioned physician in the exercise of their best judgment may deem advisable.

This authorization is given pursuant to the provision of SECTION 25.8 of the CIVIL CODE of CALIFORNIA.

This authorization shall remain effective until December 31, 2006, unless sooner revoked in writing to said agent(s).

Dated _____, 2006 Signed _____ Phone #: _____
(Father Mother, or Legal Guardian)

*Name of nearest accredited hospital will be filled in by agent(s) at time used.

NOTE: No treatment will be authorized by Representative(s) of the Piedmont Council of the Boy Scouts of America until every effort has been made to contact the parent(s) or guardian(s).

Family Insurance Co.: _____ Policy Number: _____

Doctor's Name: _____ Phone #: _____
(Area code & number)

