**YOUTH AUTHORIZATION FOR MEDICAL TREATMENT**

**Heart of Virginia Council 2024 Philmont Expedition**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ , hereby designate and appoint any one of the Adult

 (*Parent/Guardian Name) Please Print*

Advisors as appointed by the Heart of Virginia Council, Boy Scouts of America, to authorize any doctor or hospital to provide all necessary medical care, including emergency treatment or surgery, to my son, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, in the event of any sickness or injury.

 *(Scout Participant) Please Print*

I agree to accept full financial responsibility for the reasonable costs of all such care and treatment, and to release these Adult Advisors, as well as the Heart of Virginia Council, Boy Scouts of America, from any and all liability in connection with the treatment of my son.

Medical insurance is with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

Policy No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

A copy of the front and back of the medical insurance card is attached to this form.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *(Parent/Guardian Signature)*

 Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Phone: Home ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**COMMONWEALTH of VIRGINIA**

**CITY/COUNTY of \_\_\_\_\_\_\_\_\_\_\_\_\_ , TO-WIT:**

The foregoing authorization was acknowledged before me this day of , 20\_\_\_,

by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

 *(Parent/Guardian) Please Print*

 **AFFIX SEAL**

  *Notary Public Signature Notary # \_\_\_\_\_\_\_*

 My Commission Expires: