HUNGTEETSEPOPPI LODGE – Order of the Arrow
PIEDMONT COUNCIL, BSA
ORDEAL / PoppiFest WEEKEND
October 10-12th, 2014, at Camp Augusta

NAME _____UNIT_____
HOME PHONE # _____ CELL PHONE # _____
ADDRESS_____
CITY _____ZIP_____
EMAIL ADDRESS _____
DATE OF BIRTH _____ BSA ID#_____
AMOUNT ENCLOSED _____($26.00)
OR 2015 DUES _____ ($10.00, sorry I cannot attend, just paying dues)

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, 2015, unless sooner revoked in writing to said agent(s).

Dated_____, 2014 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)