



**WAIVER AND RELEASE OF LIABILITY  
Informed Consent for Scouting Activity**

I understand that participation in activities associated with the Scouting program such as the climbing/rappelling activity offered through the Los Angeles Area Council. B.S.A. on \_\_\_\_\_ (dates) involves inherent risks that could result in injury and/or death. In consideration of the benefits to be derived, and after carefully reviewing those risks involved, and in view that the B.S.A. is an organization whose membership is voluntary, and having full confidence that precautions will be taken to ensure the safety of the below named individual to participate in this activity give permission to engage in climbing/rappelling activities do hereby release and hold harmless and waive all claims I may have against: Los Angeles Area Council, B.S.A. and any volunteers, activity coordinators, employees and or organizations associated with this event. I also attest that there are no physical limitations that would place the participant at undue risk and have advised trip leaders of any pertinent health information. By signing this agreement I waive my right to bring court action to recover compensation or obtain any other remedy for any injury, death or loss of property however caused arising from participation in this activity now or in the future even though caused by negligence of those parties operating the event.

Participant Signature \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date Signed \_\_\_\_\_

**MEDICAL PERMISSION TO TREAT MINOR**

In case of emergency, I understand every effort will be made to contact me, and in the event that I can not be reached, I hereby give my permission to the physician selected by the event leaders in charge to secure proper treatment; including: hospitalization, anesthesia, surgery, injections, or medication for the participant. If participant is under 18 years of age, then this form must be also signed by parent/guardian.

Parent/Guardian Signature \_\_\_\_\_ Date Signed \_\_\_\_\_

Address \_\_\_\_\_

Telephone # \_\_\_\_\_ Physician \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Carrier \_\_\_\_\_ Account # \_\_\_\_\_