



# SOUTH AFRICAN SCOUT ASSOCIATION

## PARENT CONSENT AND INDEMNITY

(Page 1 of 2)

To The Scouter In Charge \_\_\_\_\_ Group.

I, \_\_\_\_\_  
being the parent / legal guardian of \_\_\_\_\_,  
a member of the \_\_\_\_\_ Group,  
hereby request you to allow him to take part in a camp / excursion to be held at

\_\_\_\_\_ from \_\_\_\_\_ to \_\_\_\_\_

I hereby appoint and authorise the Scouter in charge to act in my place as parent with full authority to consent to my son/daughter/ward undergoing surgical or other medical treatment. I undertake to pay the cost of such treatment. I fully understand and accept that all activities are undertaken at my son/daughter/ward own risk.

I am aware that neither the Scout Association of South Africa nor its Scouters accept responsibility for any loss, injury or damage that the person or property of my son/daughter/ward may sustain whilst engaged in any activity on the course and I waive any right that I or my son/daughter/ward may have to claim compensation against the Scout Association of South Africa or any of its Scouters or other members in respect of any loss, injury or damage incurred whilst engaged in any activity howsoever arising and whether as a result of negligence or otherwise and I indemnify them against all such claims.

Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signed \_\_\_\_\_  
*Legal Guardian*

Date \_\_\_\_\_

I hereby give consent for my son/daughter/ward to participate in water activities (should there be any) at the above mentioned camp / excursion.

Signed \_\_\_\_\_  
*Legal Guardian*

Date \_\_\_\_\_



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(Page 2 of 2)

**In the case of an emergency it is vital that the Scouter In Charge has as much personal information as possible. It is to your own benefit to fill this in completely and accurately!**

### Details of Scout

Full Names \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Allergies \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medication (specify times / dosage / etc) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Previous medical conditions or any other medical conditions you feel are of relevance  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Infectious Diseases \_\_\_\_\_

Physical Disabilities \_\_\_\_\_

Special Dietary Requirements \_\_\_\_\_

### Parents Contact Details

#### Fathers Details

#### Mothers Details

Name \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Contact First (tick)

Alternatively contact \_\_\_\_\_

### Doctor & Hospitalisation

Home Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Preferred Hospital \_\_\_\_\_

Medical Aid \_\_\_\_\_ Membership No. \_\_\_\_\_