



**HILLER AVIATION MUSEUM**

**Scout Program  
Student Information and Medical Form**

**DO NOT SUBMIT IN ADVANCE—GIVE TO INSTRUCTOR AT CHECK-IN**

The Scout Information and Medical Form must be submitted for all Scouts checked in to the supervision of Hiller Aviation Museum staff. This includes all Boy Scouts enrolled in open enrollment programs, and all Girl Scouts attending programs for which an adult from their Troop will not be present. The form is not required for Girl Scouts attending programs along with an adult from their Troop.

Scout's Name: \_\_\_\_\_ Program Date: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Phone #: \_\_\_\_\_

Please list the names of individuals besides yourself who are authorized to pick up your child.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

\_\_\_\_\_ My Scout is authorized to leave the Museum unsupervised during lunch (applies only to Boy Scout Merit Badge programs).

\_\_\_\_\_ My Scout will walk/bike/drive him/herself to and/or from the program. I authorize the Hiller Aviation Museum to dismiss him/her at program end time.

\_\_\_\_\_ I will attend program with my Scout (discounted admission fee required).

\_\_\_\_\_  
Parent Signature and Date

Please pick your Scout up on time. Late pickup fee of \$15 per 15 minutes may apply for late sign-outs.

ORAL MEDICATION must be given to Scout's Instructor. Prescription medications must be in the original bottle with a valid expiration date.

Name of Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Special Medication Instructions:  
\_\_\_\_\_

Allergies:  
\_\_\_\_\_



**HILLER AVIATION MUSEUM**

**AUTHORIZATION OF CONSENT TO TREATMENT OF A MINOR**

(I), (We), the undersigned, as parent/guardian of \_\_\_\_\_, a minor, do hereby authorize the Hiller Aviation Museum 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 rendered under the general or specific supervision of any physician and surgeon licensed under the provisions of the Medical Practices Act on the medical staff of a licensed 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 such diagnosis, treatment or hospital care which the aforementioned physician, in the exercise of his/her best judgment, may deem advisable.

This authorization shall remain in effect for six months from this date: \_\_\_\_\_ unless sooner revoked in writing and delivered to said agent(s).

We hereby give permission for my/our child to attend the Hiller Aviation Museum Merit Badge Program at the designated location. I give the instructional staff permission to take any necessary action in the event of an emergency.

\_\_\_\_\_  
Parent/Guardian (Print Name)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date