W. D. BOYCE COUNCIL

BOY SCOUTS OF AMERICA

MEDICAL CLAIM FORM

This form is to be completed and returned to the council program director after any sickness/accident which occurs at any district/ council event. The form is to be completed by the professional in charge of the event and returned within five days after the onset of the sickness/accident.

NAME OF SCOUT: ____________________

ADDRESS OF SCOUT: ____________________

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AGE OF SCOUT: __________

PARENTS NAME: ____________________

TELEPHONE NUMBER: ____________________

DO PARENTS HAVE ACCIDENT/SICKNESS INSURANCE? _____YES _____NO

IF YES, NAME OF COMPANY: ____________________

ADDRESS OF COMPANY: ____________________

POLICY NUMBER: ____________________

PACK NUMBER: __________ DISTRICT NUMBER __________

NAME OF ACTIVITY: ____________________

DATES ATTENDED ACTIVITY: ____________________

ONSET OF SICKNESS/ACCIDENT: ____________________

DESCRIBE INJURY OR ILLNESS: ____________________

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