



Troop 84

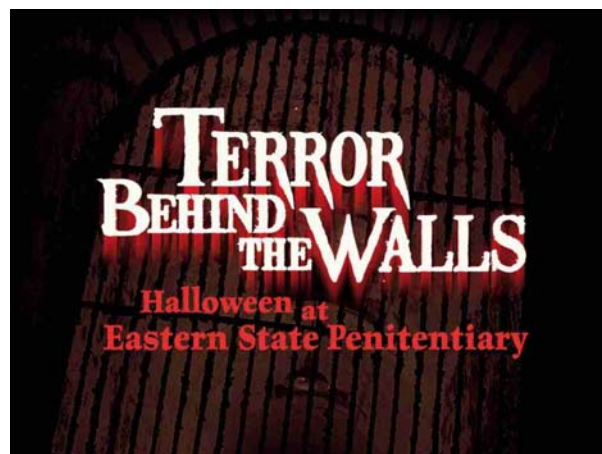


Terror Behind The Walls

Venture Night Fright Trip

#1 Haunted House in the USA!

- When: **Saturday Night, October 10th**
- Time : **6:30 PM to 11:00 PM**
- Where: Eastern States Penitentiary, Philadelphia PA
- Who: Only Venture Scouts in good standing.
- Highlights: Eastern States Penitentiary is a century-old maximum security prison. Its five prison blocks are surrounded by a 25 foot stone wall with only one entrance/exit. During the Halloween season the prison blocks are transformed into one of the best Haunted Houses in the USA. Prepare for a Scare.
- Depart: **6:30 PM** from the church parking lot.
- Return: **11:00 PM** to the church parking lot, you will be called.
- Cost: \$36 NON-REFUNDABLE!
- Signup: Signup & Permission Form due October 5th NO LATE SIGNUPS
- Wear: Comfortable clothes and seasonal jacket
- Bring: Spending Money



Terror Behind the Walls

Signup and Payment Due October 5th

Scout _____ Will Participate Will Not Participate
Parent _____ Will Participate Will Not Participate
Parent is available to provide transportation Yes No
If Driving, Number of Seat Belts (including driver) in Vehicle is

Trip Cost : \$36 Scout or Parent Total Paid : _____ by (Circle One) Cash Check Scout-Account

BOY SCOUTS OF AMERICA
TROOP 84 SOMERVILLE, NJ
WAIVER AND PERMISSION FORM

MY SON _____ HAS PERMISSION TO PARTICIPATE
(FIRST NAME) (LAST NAME)

WITH THE TROOP ACTIVITY KNOWN AS Terror Behind The Walls

WHICH WILL BE HELD AT Eastern States Penitentiary, Philadelphia, PA

MEDICAL CONDITIONS/RESTRICTIONS: _____

MEDICATIONS: _____

IN THE EVENT THAT YOU FIND IT NECESSARY FOR MY SON TO BE RETURNED HOME DUE TO ILLNESS OR OTHER REASONS, I MAY BE REACHED AT (PHONE) _____

OR AS AN ALTERNATIVE, CONTACT MR. /MRS. _____ AT _____

I hereby authorize the scout leaders to seek emergency care and further authorize the physician(s) to provide emergency treatment to my child for any laceration, fracture, other traumatic injury, any symptom, disease or injury which, in the judgment of attending physician, if untreated may be reasonably expected to increase the risk of harm to my child. This consent to care is to be in effect "only" after reasonable efforts have been made to contact and obtain my specific consent to any emergency treatment.

Parent's name (Print)

Parent's Signature

Date

In the event my son has a minor injury, I give my consent to the adult leader in charge to use his/her best judgment to decide if or when to administer the following over-the-counter medications:
Please check consented medications.

For headaches:	Acetaminophen (Tylenol)	_____
For muscle aches:	Ibuprofen (Advil)	_____
For hay fever, bee stings, poison ivy:	Antihistamine	_____
For upset stomach:	Antacid (Tums)	_____

Parent's Signature

Date