



# EMERGENCY MEDICAL AUTHORIZATION

THIS FORM ACCOMPANIES OUR CAMPERS ON TRIPS OUT OF CAMP IN CAMP VEHICLES

## CAMPER & PARENT INFORMATION

Camper's Name (first, last):

Birthdate:

Camper's Medical Alert or Drug Allergy:

Parent's Name (first, last):

Home Address:

Home Phone:

Work Phone:

Cell Phone:

Family Physician's Name:

Physician's Address:

Physician's Phone:

## PARENT'S AUTHORIZATION

PARENT'S AUTHORIZATION: If, in the event of a medical emergency involving my above named son, neither of his parents is able to be contacted immediately. I give permission and voluntarily consent to any of the emergency room physicians, qualified personnel or staff of any accredited hospital, or any duly licensed physician, to perform such diagnostic treatment or medical procedures upon my son as may be deemed necessary to stabilize his emergent condition. If my child's emergent condition is unable to be stabilized and emergency surgery and/or the administration of the anesthesia is required. I authorize same. Further treatment, blood transfusions and non-emergent care shall require specific parental instruction, or, in the event of continued unavailability of the parents, specific instructions from the party identified below as the emergency contact person. I authorize any physician, nurse, or health care provider, to communicate with the medical staff and director(s) of camp, or his/her designee, about my child's medical condition, treatment, and/or prognosis. We further authorize the camp medical staff to discuss any medical conditions with the directors, his/her designee, or the child's counselor when the medical staff, in its sole discretion, believes such communication to be in the best interest of the child.

Signature:

Date:

**IT IS ESSENTIAL FOR US TO PROVIDE MEDICAL INSURANCE INFORMATION UPON A HOSPITAL ADMISSION. WE, THEREFORE, REQUIRE THE FOLLOWING INFORMATION.**

Is your child covered by your:

Hospitalization Insurance?

Yes

No

Medical Insurance?

Yes

No

Insurance Company:

Policy Holder:

Address:

ID Number:

Group name:

Group Number:

**YOU MUST PROVIDE CAMP WITH A COPY OF THE FRONT AND BACK OF YOUR MEDICAL INSURANCE PLAN ID CARD AND YOUR PRESCRIPTION DRUG ID CARD. PLEASE DO NOT STAPLE THESE COPIES TO THE MEDICAL FORMS.**