PARENT AUTHORIZATION FORM

PLEASE RETURN BY APRIL 1ST, 2010

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:**

Policy Holder's Date of Birth: **Policy Holder's Social Security Number:**

PARENT/GUARDIAN AUTHORIZATION FOR HEALTH CARE:

This health history is correct and accurately reflects the health status of the camper to whom it pertains. It is essential to your child's safety that FULL DISCLOSURE of ALL medical conditions and medications (including those that your child has been taken off of for the summer) be made. Because of the importance of full disclosure and our dedication to safety, failure to do so could lead to your child being sent home from camp. The camper described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for my child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

I authorize any physician, nurse or other health care provider, to communicate with the medical staff and director of Camp Horseshoe, 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 director, 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.

These authorizations are limited to June 1 through August 31, 2010.

Signature: **Date:**

Is your child covered by your: **Hospitalization Insurance?** ❑ **Yes** ❑ **No**

Medical Insurance? ❑ **Yes** ❑ **No**

MEDICAL/PRESCRIPTIONS CREDIT CARD AUTHORIZATION FORM

In the unlikely event that the pharmacy/doctor does not accept my medical/drug card, I hereby authorize and permit payment for medical and/or prescription medications to: ❑ **Visa** ❑ **MasterCard**

Camper's Name:

Cardholder's Name:

Card #: **Expiration:** **3 Digit Code:**

Credit Card Billing Address:

Billing City / State: **Billing Zip:**

Signature of Cardholder: **Date:**