CHURCH CAMP EMERGENCY MEDICAL FORM

Child's Name:

Age:

Date of Birth:

Known Medical Conditions:

Known Allergies:

Current Medications:

Family Doctor:

Doctor Phone Number:

Parent or Guardian Name:

Home Phone Number:

Work Phone Number:

Cell Phone Number:

Alternate Contact Name:

Home Phone Number:

Work Phone Number:

Cell Phone Number:

IN THE EVENT REASONABLE ATTEMPTS TO CONTACT ME HAVE BEEN UNSUCCESSFUL, I HEREBY GIVE MY CONSENT FOR

1. THE ADMINISTRATION OF ANY TREATMENT DEEMED NECESSARY BY A LICENSED PHYSICIAN OR DENTIST.
2. THE TRANSFER OF THE CHILD TO ANY HOSPITAL REASONABLY ACCESSIBLE. THE AUTHORIZATION DOES NOT COVER

CONCURRING IN THE NECESSITY FOR SUCH SURGERY ARE OBTAINED PRIOR TO THE PERFORMANCE OF SUCH SURGERY.
I FURTHER RELEASE _____ CHURCH AND ALL THEIR YOUTH SUPERVISORS
FROM LIABILITY DURING THE COURSE OF THIS EVENT.

(signature of parent / guardian) date NOTARY