2017 Architecture and Design Camp
Medical Information
Consent for Medical Treatment of a Minor Child

Name of Program: _____

Date(s) of Program: _____

Child's Name: _____ Birth Date: _____

Parent/Guardian Name: _____

Street Address: _____

City, State, Zip Code: _____

In case of an emergency, where can you be contacted if not at home? _____

Daytime phone (mother): _____ Daytime phone (father): _____

Health Insurance Company: _____

Policy Holder's Name: _____ Group Number: _____

Family Physician: _____ Phone: _____

Please record important information that Camp Staff should be aware of with regard to: food or plant allergies, insect bites, sensitivities, disabilities, health problems, behavior issues, etc.

_____

_____

_____

Please advise us if your child requires medication (Yes) _____ (No) _____

Name of medication: _____

Dosage: _____

Special Instructions: _____

_____

In case of accident or serious illness, I request that Camp personnel contact me. If Camp personnel are unable to reach me, I hereby authorize Camp personnel to call the Physician indicated above and to follow his/her instructions. If it is impossible to contact this physician, I authorize Camp personnel to make whatever arrangements are deemed necessary on behalf of my child. If the accident or illness demands immediate attention, I authorize Camp personnel to arrange emergency medical care.

Signature of Parent or Guardian: _____

Date: _____