Adult Architecture Camp
Medical Information
Consent for Medical Treatment

Name of Program: ____

Date(s) of Program: ____

Camper's Name: ________________________________Birth Date: ________________________

Street Address: ____

City, State, Zip Code: ____

Emergency contact person:___________________________________

Emergency phone: ___________________________________

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 allergies or medication:

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In case of accident or serious illness, 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 my behalf. If the accident or illness demands immediate attention, I authorize Camp personnel to arrange emergency medical care.

Signature: ____

Date: ____