

French Summer Camp Permission to Treat or Administer Emergency Medical Care/Authorization to Release Medical Information

I/We, the undersigned Parents/Guardians, in the event of an emergency, give permission for the evaluation and treatment, in our absence, of the above named student as deemed necessary by a currently licensed health care provider, hospital, emergency medical services or camp staff. Every effort will be made to contact the parent/guardian. Care of the injured student will be provided as needed. Care will not be withheld until parent arrives or are notified. I/We understand that the parent/guardian is completely responsible for the financial costs incurred with treatment.

I/We, the undersigned, authorize the release of medical information, gathered in the course of a camp emergency, to the listed medical care providers and emergency response personnel. I/We authorize the listed medical providers to share any "personal health care information" that will support the health of the camper while in program with the designated Health Care staff.

Signature of Parent/Guardian	Date	Signature of Parent/Guardian	Date
Ith Care Provider Information:			
		Telephone:	
Dentist:		Telephone:	
Insurance Coverage Yes No Company/Carrier Name:			
dical History:			
My child will take daily or emergency me Name of drug, dose, frequency, time to l		ring the program day. Yes No Ite drug therapy started or to be started for each me	ed to be given.
Does your child routinely take daily med	ication at ho	5 1 71	, ,
Does your child(ren) have any disease or	chronic illn	ess we should know about? Please list below.	
Does your child currently have Asthma? taken:		No If yes, list frequency of asthma attacks, date of la	st attack and meds
	norization to	No If your child has a strong allergic reaction to an Administer Medication in Program" form for oral B ked.	
Food/Medication Allergies:		Treatment:	
Contact Allergies (bug bites, airborne var			

Treatment: Rea	action/Reaction Time:	
Has your child been diagnosed or treated for a vision, Does your child wear glasses/contacts or hearing aids Has your child been diagnosed or treated for behavior of the second of the	s: Yes No Explain:	
If yes, please explain:		
by a licensed health care provider. This includes nebulizer of the skin and all over the counter medication (OTC's) such as parent/guardian does not authorize the nurse or designee t medications or treatments the "Authorization to Administer parent/guardian must provide to the Director the prescribe on each bottle. All labels must include the camper's name,	pocket or backpack unless special permission is granted. All medicat	ng changes to ne nister any nardian. The narmacy label
I/We have read and will abide by the program's medication	n policy.	
	Parent/Guardian Signature	Date