



Consent to Treat

This form **MUST** be completed by the first day of camp. A separate form must be completed for each child.

Camper Information
Name: _____
Grade Entering: _____ DOB: _____ Male or Female: _____
Address: _____ City: _____ Zip: _____
Please list any allergies, medicines or medical conditions: _____ _____
Please complete PART 1 or PART 2, DO NOT complete both
PART 1: To Grant Consent
I hereby give consent for the administration of any treatment deemed necessary by the physician, dentist, specialist and/or hospital listed below: OR in the event the designated preferred practitioner or hospital is not available, by another licensed physician or dentist or any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists concurring in the necessity of such surgery are obtained prior to the performance of such surgery.
Physician: _____ Phone: _____
Medical Specialist: _____ Phone: _____
Preferred Hospital: _____ Phone: _____
Dentist: _____ Phone: _____
Parent/Guardian Signature: _____ Date: _____
PART 2: Refusal to Consent (DO NOT complete if PART 1 is completed)
I DO NOT give consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the camp authorities to take the following action: _____ _____
Parent/Guardian Signature: _____ Date: _____