Consent to Medical Treatment
Authorization to Release Information

I, _____ the undersigned parent or guardian of
Print Name

_____
Print Minor's Full Name

a minor, do hereby consent to any x-ray, examination, anesthetic, medical or surgical diagnosis or treatment, and hospital service that may be rendered to said minor under the general or special instructions of:

_____
Name of Minor's Physician (Please Print) Physician's Telephone Number

or any physician the group leader or his/her designee may call, whether such diagnosis or treatment is rendered at the office of said physician, at a licensed hospital, or at the camp. It is understood in the case of a major accident or illness reasonable effort will be made to reach the doctor listed above before the group leader or his/her designee calls any other physician.

It is further understood that this consent is given in advance of any specific diagnosis or treatment, which might be required and is given to authorize the camp, group leader, designee or the physician to exercise his/her best judgment as to the requirements of such diagnosis or treatment.

This consent shall remain in continuous effect until revoked in writing or until the parent or legal guardian in person takes charge of said minor. We hereby authorize any hospital or physician, or any other person who attended to or examined said minor to furnish the groups insurance company or its representative any and all information with respect to any illness, medical history or consultation, prescriptions or treatment, and copies of all hospital or medical records.

A photocopy of this authorization shall be considered as effective and valid as the original.

Signed Parent or Legal Guardian Date

Signed Adult Witness Date

Please print all medications being taken:	**Please print any known allergies:**
_____	_____
_____	_____
_____	_____

Please describe any current physical, mental, or psychological conditions requiring medication, treatment, or special restrictions or consideration while at camp.

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