Medical Treatment Authorization Form

_____

Participant's Name

Camp Attending_____

List any medical conditions that camp personnel should be aware of:_____

_____

List any medications currently taking:_____

_____

List any allergies:_____

In case of emergency please contact:

_____

Name

Daytime Telephone_____

Nighttime Telephone_____

Medical Insurance company_____

_____,as parent or legal guardian of the participant named above, do hereby authorize the director of the sports camp and his or her subordinates, to seek any medical and/or surgical treatment for the care of my child. The program director is authorized to provide medical treatment for my child, and I shall be fully responsible for honoring such costs. I also authorize the medical facility to release all information needed to complete insurance claims. I authorize the insurance payment directly to the medical facility.

_____ _____

Signature (Parent or Guardian) Date