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# ST. PAUL LUTHERAN SUMMER CAMP

## EMERGENCY AUTHORIZATION FORM 2018

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under church authority, when parents or guardians cannot be reached.

Student's Name	Grade	Teacher	Birth Date

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

In accordance with the Missing Children's Act, the camp needs a phone number where a parent or guardian can be reached during camp hours.

Parent Name	Relationship	Home Phone	Cell phone or pager	Work phone & Work hours
	Mother			
	Father			

If parents are divorced, which parent has legal custody? \_\_\_\_\_

May non-custodial parent be contacted? YES \_\_\_ NO \_\_\_ Non-custodial Parent's Name \_\_\_\_\_

If custodial parent is remarried, may the school contact the step-parent in regard to camp-related matters?

YES \_\_\_ No \_\_\_ Their Name \_\_\_\_\_ Phone No. \_\_\_\_\_

In the event reasonable attempts to contact the above named parent or guardian have been unsuccessful, please list two relatives or neighbors who are willing to assume the responsibility for your child:

If Parents can't be reached contact:	Relationship	Home Phone	Cell phone or pager	Work phone & Work hours

**CONTINUED ON BACK**

(Part I OR Part II must be completed, not both)

## PART 1 – TO GRANT CONSENT

I hereby give my consent for any treatment deemed necessary by the following or by another licensed physician or dentist in the event the preferred practitioner is not available:

<b>Preferred Physician</b>	<b>Phone #</b>
<b>Preferred Dentist</b>	<b>Phone #</b>
I give permission for the transfer of my child/ren to the following or any hospital that is reasonably accessible:	
<b>Preferred Hospital</b>	<b>Location</b>

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

## ADDITIONAL HEALTH INFORMATION

Facts concerning the child/ren's medical history including allergies (**particularly to animals**), medications being taken, physical impairments and any other information that might be important to the health and well being of your child/ren:

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PARENT / GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

## PART II – REFUSAL TO CONSENT

**\*\*\*DO NOT COMPLETE PART II IF YOU HAVE COMPLETED PART I\*\*\***

I do **NOT** give my consent for emergency medical treatment of my child/ren. In the event of illness or injury requiring emergency treatment, I wish the church to take **NO ACTION** or to follow this procedure:

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PARENT / GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_