AUTHORIZATION FOR MEDICAL TREATMENT OF MINORS

If your child needs medical, dental, health or hospital services, under the law, you as a parent must give permission as the need arises. By law a hospital is always required to attempt to contact parents and/or legal guardians to gain consent for treatment. This form can provide valuable information to health care providers for contacting parents or guardians. The hospital still, however, has the obligation to always attempt to contact parents or guardians. Medical care often requires complex decisions that are best made when parents or guardians are involved. When a true emergency exists, a child may be treated without parental consent. This will happen only when a physician determines that a child needs immediate medical care and an attempt to obtain parental consent would result in a delay which would increase the risk to the child's life or health.

I (we), being the parent(s) of custody or legal guardian(s) of (print name of minor)_____ do hereby appoint **Camp Northwoods**, **Skidmore College** to act on my behalf in authorizing unexpected medical, dental or surgical care, or hospitalization for said minor in my absence and I authorize **Camp Northwoods, Skidmore College** to grant consent to medical doctors and emergency staff at a hospital/emergency facility to conduct the required tests and provide the necessary medical treatment/care to the above named child IF I OR MY SPOUSE CANNOT BE REACHED. I understand that every reasonable effort will be made to contact me. I understand that the consent and authorization herein granted are valid only during camp June 30-August 15, 2014.

Child's birth date_____ Date of last Tetanus immunization _____

Pertinent medical data (allergies, asthma, seizures, etc. Include any medication the child is on, relative to this condition.)_____

Medical Restrictions_____

Mother/Guardian *(print)*_____

Address _____

Signature _____ Date _____

Phone # (work) _____ (home)_____

(cell) _____

Father/Guardian *(print)* _____

Address_____

Signature _____ Date _____

Phone # (work) _____ (home)_____

(cell) _____

Name of Family Physician _____

Phone # _____

Address_____

MEDICAL INSURANCE INFORMATION

Guarantor (person responsible for payment of bill) _____

Name of Insurance_____

Policy #_____

Please complete other side.

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