



PERMISSION FOR EMERGENCY MEDICAL TREATMENT

CAMPER FIRST NAME _____ LAST NAME _____ MIDDLE INITIAL _____

BIRTH DATE _____ SOCIAL SECURITY NUMBER _____ PHONE NUMBER _____

EMERGENCY PHONE NUMBERS:

The information you provide on this form tells us what to do in case your child becomes ill or is injured while at this camp. We need to know a phone number where you can be reached during the day and at night. If we are unable to reach you, we also need one or two additional phone numbers (the child's other parent, a relative, or a close family friend.)

FIRST PERSON TO BE CONTACTED _____ RELATIONSHIP TO CHILD _____ DAYTIME PHONE _____ EVENING PHONE _____

SECOND PERSON TO BE CONTACTED _____ RELATIONSHIP TO CHILD _____ DAYTIME PHONE _____ EVENING PHONE _____

THIRD PERSON TO BE CONTACTED _____ RELATIONSHIP TO CHILD _____ DAYTIME PHONE _____ EVENING PHONE _____

MEDICAL INFORMATION:

Physical conditions, medical history, allergies, and medications being taken. If your child is sensitive to bee stings please note below. You will receive additional information to be completed by your physician. Be sure to include ALL medical conditions that we should know about (concussions, seizures, asthma, allergies, toileting problems, glasses, etc.)

RESTRICTIONS ON ACTIVITIES:

Is there any activity that your child cannot do at this camp due to a medical condition? Please list:

My son/daughter may be given Acetaminophen/Ibuprofen upon request (Please mark one) YES NO

PERMISSION TO PROVIDE MEDICAL TREATMENT

After reasonable attempts to contact me have been unsuccessful, I give permission for the administration of any treatment deemed necessary by:

PREFERRED PHYSICIAN _____ PHYSICIAN PHONE NUMBER _____

PREFERRED DENTIST _____ DENTIST PHONE NUMBER _____

or, if the preferred physician or dentist is not available, by another licensed physician or dentist, in the event that urgent care is needed, I give permission for my child to be transported to the nearest hospital by life squad. This authorization does not cover major surgery unless the medical opinions of two licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

PARENT OR GUARDIAN SIGNATURE _____ DATE _____

PERMISSION TO USE PHOTOGRAPHS

For the purpose of advertising; I (we) give permission for Champions Choice and their sponsors to use photographs of participants during camps and after showmanship performances:

Parent or Guardian Signature _____ Camper Signature _____

DO NOT SIGN THIS PORTION OF THE FORM IF YOU HAVE GIVEN PERMISSION FOR EMERGENCY MEDICAL TREATMENT

I DO NOT give my permission for emergency medical treatment of my child. I DO NOT give permission for treatment by a physician, dentist, transfer to a hospital, or for my child to be transported by Life Squad.

In the event of illness or injury requiring emergency treatment, I wish the camp authorities to TAKE NO ACTION OR TO:

PARENT OR GUARDIAN SIGNATURE _____ DATE _____