EMERGENCY MEDICAL TREATMENT STATEMENT

****Signature MUST be notarized****

Legal Name of Child: _____ D.O.B.: _____

(Last) (First) (Middle)

Address: _____

Gender: _____ Date of last Tetanus shot (if known): _____

Any Medical conditions we should be aware of:

_____

ALL MEDICATIONS MUST BE IN ORIGINAL PRESCRIPTION CONTAINER

Name of Medication Dosage Reason for Medication

1. _____

2. _____

3. _____

If additional medications are required, please list on back of page.

The Kentucky District Children's Camp nurse may give the above-named child, age/weight appropriate doses of over-the-counter medications, ONLY WITH PARENT/GUARDIANS PERMISSION.

Name of child's doctor: _____ Phone: _____

Name of Medical Insurance Company: _____ Phone: _____

Policy #: _____ Group #: _____

Name of Policyholder: _____

Please attach a copy of the insurance card if possible.

I, _____, legal parent or guardian of _____

give my permission for emergency medical treatment in the event of accident, sickness, or injury while my child is attending Kentucky District Children's Camp. I also give permission for my child to receive as needed during Kentucky District Children's Camp the over-the-counter medications. I waive all claims against the Kentucky District Church of the Nazarene, Board, or any representatives because of injury, illness, or damage of property of the above-named camper.

_____ _____

Signature of Parent/Guardian Date

_____ _____

Signature of Notary Date

My Commission expires on _____