USL SUMMER CAMP MEDICAL EMERGENCY AUTHORIZATION

Child Name_____
Home/Cell Phone_____
Address_____
Date of Birth_____

The purpose of this form is to authorize the provision of emergency treatment for children who become ill or injured while involved in the "USL Summer Day Camp" Program when parents or guardians cannot be reached. ***Part I or II Must Be Completed.***

Part I- To Grant Consent

Mother's Name _____ Home/Cell Phone_____

Work Phone_____

Father's Name_____ Home/Cell Phone_____

Work Phone_____

Local alternate persons to contact in case neither parent can be reached:

Name_____ Relation to child _____

Home/Cell Phone_____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) The administration of any treatment deemed necessary by the above-named Doctor or Dentist, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible.

Doctor to be Called_____ Phone_____

Dentist to be Called_____ Phone_____

Preferred Local Hospital _____

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. Facts concerning the child's medical history, including allergies, medications being taken, and physical impairments to which a physician should be alerted:
Signature of parent or guardian_____ Date_____

Part II-Refusal to Consent
I do not give my consent for emergency treatment of my child. In the event of illness or injury requiring emergency treatment, I request the staff of "USL Summer Camp"

To:_____

Signature of parents or guardian_____ Date_____

Signed (Parent)_____ Date_____