Presbyterian Church of Palm Harbor
EMERGENCY FORM SUMMER CAMP
KINGDOM KIDS CAMP 2017

A: STUDENT INFORMATION:
Student Name: ____

Address: ____

Telephone Number ________________ Date of Birth: _______________

Male OR Female

Grade Completed _____________ School_________________

T-SHIRT SIZE________

B: PARENTS/GUARDIANS: EACH TO BE LISTED SEPARATELY:
1. Name Relationship ____

Address Home Phone____

Employer Office Phone____

Cell Phone ____

2. Name Relationship____

Address Home Phone ____

Employer Office Phone ____

Cell Phone ____

C: IN THE EVENT PARENTS/GUARDIANS CANNOT BE REACHED, CHILD MAY BE RELEASED TO:
(Minimum of two contacts)
Name Relationship Daytime #s ______________________________________

Name Relationship Daytime #s ______________________________________

Name Relationship Daytime #s ______________________________________

Should none of the above contacts be available, I hereby authorize the administration of any treatment deemed necessary by the following:
Preferred Physician/phone: ____

In the event of a life-threatening emergency or unavailability of preferred doctors, I authorize another licensed physician and/or the transfer of my child to the following hospital or any hospital reasonably accessible:

D. Preferred Hospital: ____
This authorization does not cover major surgery unless the medical opinion of two licensed physicians,

concurring the necessity for such surgery, is obtained prior to the performance of the surgery. All doctors should be alerted to the information on this form concerning my child's medical history (allergies, medications, physical impairments, etc.)

Parent/Guardian Signature ______________________________ Date: __________

REFUSAL OF CONSENT:

I DO NOT GIVE CONSENT FOR EMERGENCY MEDICAL TREATMENT OF MY CHILD. IN THE EVENT OF ILLNESS OR INJURY REQUIRING TREATMENT, I WISH THE SCHOOL TO TAKE NO ACTION OR TO:

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Date Parent/Guardian Signature

MEDICAL INFORMATION

It is the sole responsibility of the Parent/Guardian to provide accurate medical information and updates in writing. PLEASE PROVIDE CLEAR AND LEGIBLE INFORMATION concerning the following, if applicable: Health, allergies, medication.

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Please attach or make a copy of the front and back of insurance card (s)