**SUMMER CAMP**

**MEDICAL AUTHORIZATION FORM**

SHOULD IT BE NECESSARY FOR MY CHILD TO RECEIVE MEDICAL TREATMENT WHILE PARTICIPATING IN CAMP, I HEREBY GIVE THE ADULTS IN CHARGE PERMISSION TO USE THEIR JUDGEMENT IN OBTAINING MEDICAL SERVICES FOR MY CHILD. I GIVE PERMISSION TO THE PHYSICIAN SELECTED BY CAMP EATON TO RENDER MEDICAL TREATMENT DEEMED NECESSARY AND APPROPRIATE BY THE PHYSICIAN. I UNDERSTAND THAT SUCH MEDICAL OR HOSPITAL COSTS INCURRED FOR MY CHILD SHALL BE MY SOLE RESPONSIBILITY

CHILD’S NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PARENT/GUARDIAN NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOME PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WORK PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CELL PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE INDICATE ANY SPECIAL INSTRUCTIONS/ALLERGIES ETC.

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SIGNATURE OF PARENT/GUARDIAN