

**HOPE CHAPEL OF STERLING H2O SUMMER CAMP**  
**AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT**

Students Name \_\_\_\_\_  
(Last) (First)

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone \_\_\_\_\_ Date of Birth \_\_\_\_\_ Adult Email \_\_\_\_\_

In an emergency notify \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Family Doctor \_\_\_\_\_ Phone ( ) \_\_\_\_\_

PHYSICAL CONDITION (Check and specify; If other than good, give details)

- Allergies
- Asthma
- Diabetes
- Stomach upsets
- Frequent colds
- Heart Condition
- Rheumatic Fever
- Eye, ear, nose, throat
- Epilepsy or other nervous system disorder
- Date of last Tetanus shot \_\_\_\_\_
- Date of last Polio Vaccine \_\_\_\_\_
- Other \_\_\_\_\_
- Any activity restrictions (give details on back of this form)

Medication \_\_\_\_\_

**Insurance Company** \_\_\_\_\_ **Policy Number** \_\_\_\_\_

Does Youth carry copy of insurance card with him/her \_\_\_\_\_

I/we \_\_\_\_\_, the parent (or legal guardian) of the above-named child, hereby give my/our consent to youth participation in the scheduled youth activity. I/we assume all risks and hazards incidental to such participation, including transportation to and from the activity, and I/we hereby waive, release, absolve, indemnify, and agree to hold harmless Hope Chapel of Sterling sponsors, supervisors, organizers, and persons transporting my/our child to or from such activity, for any claims out of an injury to my/our child, except to the extent and in the amount covered by accident or liability insurance.

I/we, the undersigned, parent(s) or legal guardian(s) of \_\_\_\_\_ MINOR, Do hereby authorize Kenneth Hall or/church youth staff member for the undersigned to consent to any X-ray, anesthetic, medical or surgical diagnosis of treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and/or surgeon licensed under state provision, on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given of any specific diagnosis, treatment or hospital care being required and is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his best judgement may deem advisable.

I know of no health reason why my son/daughter may not participate in any Youth Ministry activities.

SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Business Phone: ( ) \_\_\_\_\_