Last Name _____

CAMP CHRISTMAS 2025

FAMILY AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Student's Name_____ Date of Birth _____ Male/Female *Circle One*

Address_____City_____State_____Zip_____

In the event of a medical emergency, if the school is unable to notify me or a temporary caregiver(s), I hereby authorize the Camp Director or Director designee to have my child transported to a clinic or to a hospital for emergency treatment. I will be responsible for all costs incurred.

Parent/Guardian Signature _____ Date _____

Physician's Name _____ _____ Phone # _____ Preferred Hospital _____

Health Insurance Policy #_____ Company _____ Policy Holder Name _____

MEDICAL ALERT INFORMATION (i.e., allergies, medical conditions, handicapping conditions)

_____

_____

FAMILY AND CAMPER INFORMATION

Father's/Guardian's Name _____ Email _____

Cell Phone # _____ Home Phone #_____

Work Phone #_____Employer_____

Mother's/Guardian's Name _____ Email _____

Cell Phone # _____ Home Phone #_____

Work Phone #_____Employer_____

Local person to contact if parent(s) are not available: _____ Phone #_____

Camp Seven Rivers has my permission to release my child to the persons listed below for transportation or to assume temporary care or responsibility of my child in case of emergency.

Name_____Relationship_____Phone #_____

Name_____Relationship_____Phone #_____

Name_____Relationship_____Phone #_____

Name_____Relationship_____Phone #_____

Name_____Relationship_____Phone #_____

Name_____Relationship_____Phone #_____