

Last Name _____

A DAY IN BETHLEHEM 2026

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 # _____

Seven Rivers Church 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 # _____