

OAGC NATURE STUDY CAMP - EMERGENCY MEDICAL AUTHORIZATION

Child's name _____
Address _____

PURPOSE To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under child care authority when parents or guardians cannot be reached.

PART 1 – TO GRANT CONSENT

In the event of reasonable attempts to contact me at _____
or _____ Or other parent or guardian at _____
or _____ have not been successful, I hereby give my consent for:

1. The administration of any treatment deemed necessary by:

Physician _____

Address _____

Phone _____

Dentist _____

Address _____

Phone _____

1. In the event the preferred practitioner is not available, treatment may be given by another licensed physician or dentist.
2. The transfer of my child to: _____ or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history, including allergies, medications being taken, any physical impairments to which a physician should be alerted _____

Signature of parent or guardian

Date _____

PART 11 – CONSENT REFUSAL

I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the camp provider to take no action or to: -

Signature of parent or guardian

Date _____