



Keith Shirley, Director

Josh Tate, Asst. Director

Lisa Richard, Food Service Director

PO Box 1736, Idyllwild, CA, 92549

(951) 659-2739

camp_maranatha@juno.com

AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR

(I) (We), the undersigned, being the parent(s)/legal guardian(s) of _____, a minor, do hereby authorize the adult staff at Camp Maranatha as agent(s) for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the Medical Practices Act on the medical staff of any accredited 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 in advance of any specific diagnosis, treatment or hospital care being required but 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 judgment may deem advisable.

This authorization shall remain effective beginning ____/____/____ until ____/____/____ unless sooner revoked in writing delivered to said agent(s).

Signature _____ Date _____

Relationship to Minor _____

Signature _____ Date _____

Relationship to Minor _____

Witness Signature _____

Witness Signature _____

**PLEASE ATTACH TO THIS FORM A PHOTOCOPY OF
THE ABOVE NAMED MINOR'S INSURANCE CARD AND
IMMUNIZATION RECORD.**

MEDICAL INFORMATION AND EMERGENCY CONTACT INFORMATION

NAME OF SUMMER STAFF MEMBER:

EMERGENCY CONTACT INFORMATION

NAME OF PARENTS OR LEGAL GUARDIANS:

CELL PHONE:

HOME PHONE:

WORK PHONE:

ADDRESS:

EMERGENCY CONTACT OTHER THAN PARENT/LEGAL GUARDIAN:

NAME:

CELL PHONE:

HOME PHONE:

WORK PHONE:

ADDRESS:

MEDICAL INFORMATION:

Check all applicable conditions of Summer Staff Member and explain below:

Allergies (General)

Respiratory Problems

Allergy to bee stings

Sinus Trouble

Asthma

Sleep Walking

Backaches or weak back

Any food allergies

Bowel or bladder problems

Depression

Car/sea sickness

Mental Illness

Diabetes

Please explain in greater detail any of the conditions you marked above (use a separate sheet of paper if additional space is required.).

Epilepsy or convulsive disorder

What important medical needs should Camp Maranatha be aware of? Please explain in detail using a separate sheet of paper if additional space is required.

Hay fever

Frequent recurrent headaches

Heart trouble or murmur

Date of last Tetanus shot?

Poison Oak

SEE REVERSE

MEDICATION:

Is your child required to take regular medication? YES NO

If so, please list all medications, and describe in detail the instructions for administration of the medications.

Is your child in the habit of administering the medication to him/herself?

Check those non-prescription medications we may have permission to give your child under the supervision of an Adult Staff Member:

Kaopectate (for diarrhea)	yes	no	Additional Comments:
Pepto Bismol (for upset stomach)	yes	no	Additional Comments:
Milk of Magnesia (for constipation)	yes	no	Additional Comments:
Throat Lozenges (for sore throat)	yes	no	Additional Comments:
Caladryl (for skin rashes)	yes	no	Additional Comments:
Acetaminophen (Tylenol generic for Headaches or elevated temperatures)	yes	no	Additional Comments:
Sudafed	yes	no	Additional Comments:
Ibuprofen	yes	no	Additional Comments:
Cough Drops	yes	no	Additional Comments:
Benadryl	yes	no	Additional Comments:
Other _____	yes	no	Additional Comments: