



# CAMP O-AT-KA

## INFORMATION/AUTHORIZATION FORM

Camper Name:	Session:	Date:
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<b>SUMMER ADDRESS</b>	PHONE
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<b>WORK/FATHER</b>	WORK PHONE	CELL PHONE
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<b>WORK/MOTHER</b>	WORK PHONE	CELL PHONE
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<b>EMERGENCY CONTACT #1</b>	DAYTIME PHONE	RELATIONSHIP
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<b>EMERGENCY CONTACT #2</b>	DAYTIME PHONE	RELATIONSHIP
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<b>EMERGENCY CONTACT #3</b>	DAYTIME PHONE	RELATIONSHIP
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<b>FAMILY PHYSICIAN/PEDIATRICIAN</b>	ADDRESS	PHONE
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<b>FAMILY DENTIST</b>	ADDRESS	PHONE
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### EMERGENCY MEDICAL AUTHORIZATION

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature:
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### MEDICAL COVERAGE

POLICY HOLDER	POLICY HOLDER NAME	POLICY HOLDER DOB
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CHILD'S DATE OF BIRTH (M/D/YR)	ALLERGIES
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MEDICATIONS (SPECIFY)	LAST TETANUS SHOT (M/YR)
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<b>OTHER PERTINENT MEDICAL INFORMATION</b>

Please enclose a copy of your medical card - both sides

