



EOYC Consent to Treat Form for Emergency Treatment

Name: _____ for _____
___ mother ___ father ___ guardian ___ son ___ daughter

Age _____. Date of Birth: _____

I hereby voluntarily consent to the rendering of emergency care, including diagnostic procedures, surgical and medical treatment and blood transfusions, by authorized members of the hospital staff or their designees, as may in their professional judgment be necessary.

I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on my child's condition. I have read this form and certify that I understand its contents.

I hereby give my consent to: the EOYC nurse and/or Camp Director to care for my child.

Camper Name: _____

during the week of EOYC, _____ to _____, year _____
to arrange for emergency medical/dental care and treatment necessary to preserve the health of my child.

I acknowledge that I am responsible for all reasonable charges in connection with care and treatment rendered during this period.

Name of Insurance Policy holder: _____

Address: _____

Telephone: _____

Health Insurance carrier: _____

Group no: _____ ID: _____

Family physician or pediatrician name and contact information: _____

Allergies and/or pertinent medical history: _____

Medications: _____

Signature: _____ Date: _____

*****Please sign and date this in front of a Notary Public.*****

State of: _____ County of: _____

Signed or attested before me on _____ (date) By _____ (name of person)

(signature of Notarial officer)

(seal)