CAMP-of-the-WOODS SUMMER STAFF 2024

Authorization and Permission to Provide Necessary Treatment or Emergency Care

This health history is correct and complete as far as I know, and the person herein described has permission to engage in all Camp activities except as noted. I hereby give permission to the medical personnel selected by CAMP-of-the-WOODS to order X-rays, routine tests, and/or seek emergency medical treatment. I agree to the release of any records necessary for insurance purposes and give my permission to arrange necessary related transportation for me. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by Camp Nurse and their Assistant(s) to secure and administer treatment, including hospitalization, for the person named below. The completed form may be photocopied for trips out of Camp**.**

Staff signature: _____

Print Name: _____

Email: _____

Cell #: _____

Date: _____

If Under Age of 18 – Parent or Guardian:

Name: _____ Signature: _____

Contact Telephone Number in case of emergency: _____

Reviewed by Member of COTW Medical Staff

Print Name: _____ Signature: _____

Date: _____