

Authorization For Consent To Treatment Of Minors

Full name of minor: _____ Date of Birth: MM/DD/YY
Name of person responsible for this minor during camp week: _____

Where will this person responsible for the above minor be staying? _____
Phone: () _____

Please list the allergies your child may have (e.g. medications, foods, insect bites):

Please list any medication your child is presently taking and for what reason.

Medication	Reason
_____	_____
_____	_____
_____	_____

Does your child have a medical history of the following?

Asthma: <input type="checkbox"/>	Hypoglycemia: <input type="checkbox"/>
Hay Fever: <input type="checkbox"/>	Bleeder: <input type="checkbox"/>
Epilepsy: <input type="checkbox"/>	Migraines: <input type="checkbox"/>
Heart Problems: <input type="checkbox"/>	Anxiety Disorder: <input type="checkbox"/>
Diabetes: <input type="checkbox"/>	Taking Insulin? <input type="checkbox"/> Y <input type="checkbox"/> N
	Dosage: _____

Date of last Tetanus shot: MM/DD/YY

Name of child's Doctor: _____ Phone: () _____

Is this minor covered by medical insurance? Y N

Name of medical insurance company: _____

Policy Number: _____

(Please attach a copy, both front and back, of your insurance card)

I, _____ Phone: () _____
of _____

(street address, City, State, Zip)

hereby state that I am the Parent, or Legal Guardian of the above named child and that I authorize any necessary emergency medical treatment for the above named child while participating and being cared for by the Believers' Christian Fellowship Ohio Family Camp at 1695 Stewart Road, Lima, OH 45804, (419) 221-0085, for the duration of the camp (July 7-10, 2011).

Signature of Parent or Guardian: _____ Date: _____