The MacDuffie School

PERMISSION FOR MEDICAL TREATMENT SUMMER PROGRAM

Participant's Name:_____ **DOB:** _____ **Grade:** _____

I/we, _____, the parent(s) or legal guardian(s) of the camp participant list above authorize The MacDuffie School to give permission for emergency medical treatment for the above named child at the most appropriate medical facility, in the event that I/we cannot be contacted. I/we consent to provide payment for all services not covered by a health insurance policy.

I/we give the medical staff at The MacDuffie School and the PCP, specialist, and any medical personnel that may be required, two way consent to share information that may be pertinent to my child.

Parent/Guardian Name (print):_____

Parent/Guardian signature:_____Date: _____

****This authorization expires on the last day of summer camp of the year signature date****

Insurance Company: _____ Policy Holder's Name: _____

Policy Holder's Company Number: _____ Policy Number: _____

Brief Medical History: ***please check all that apply***

Yes	No		
□	□	Concussion	If yes, how many: _____ Date of most recent: _____
□	□	Diabetes	If yes, controlled by: _____
□	□	Asthma	If yes, controlled by: _____
□	□	Seizures	If yes, controlled by: _____ Date of last: _____
□	□	Allergies:	to bees sting_____;
			to food: _____ ;
			to medication: _____;
			to other: _____
□	□	Medical issues not listed above: _____	
□	□	Use of Medications (not listed above):	

If yes, identify (**include medication taken at home**):

_____

_____

_____