

The Episcopal Diocese of Montana

Camp Marshall Medical Release Form

(PLEASE PRINT AND COMPLETE BOTH PAGES)

Camper's name: _____
Last First Middle

My child will attend _____ Bunkmate Request _____

First Time with this program (Y) (N) Used to being away from home (Y) (N)

Male Female Birth date (mm/dd/yyyy): _____ Grade next year _____

Address _____ City _____ State _____ ZIP _____

Email: _____

Primary Parent (or guardian) Name _____
Last First

Preferred Phone (h) (w) (c) _____ Secondary Phone (h) (w) (c) _____

Parent (or guardian) Name _____
Last First

Preferred Phone (h) (w) (c) _____ Secondary Phone (h) (w) (c) _____

If parent(s)/guardian(s) are not available **in case of emergency**, please notify:

Last First Middle Phone Relationship to Child

Last First Middle Phone Relationship to Child

Participation:

I give permission for my child to participate in all activities, field trips, swimming activities, and to be transported as part of the Camp Marshall or Youth Program experience.

Camp health care staff members are authorized to share this form and its information with the Camp Director, his/her designee, and the camper's counselor

Authorization to consent to treatment of minors:

I/we, the undersigned, parent(s) or guardian(s) of the above mentioned youth, a minor, do hereby authorize The Episcopal Diocese of Montana, Director of Camp Marshall & Youth Programs or his/her Designee as agent(s) and/or chaperone(s) for the undersigned to consent to any x-ray, examinations, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by,

and is to be rendered under the general or special supervision of, any physician and surgeon who is licensed to practice in the state of Montana, whether such diagnosis or treatment is rendered at the office of said physician or at any hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his/her best judgment may deem advisable.

This authorization shall remain effective through the completion of the registered program, unless sooner revoked in writing delivered to said agent(s).

I understand the above and have completed the information to the best of my ability. The health history information that follows is correct to the best of my knowledge and the person herein described has my permission to engage in all activities except as noted.

Signature of parent or guardian

Date

Witness

Date