



**STUDENT AUTHORIZATION FOR
EMERGENCY MEDICAL TREATMENT**

Camper Name: _____ DOB: _____

Address: _____ Phone: _____

Guardian Name: _____ Phone: _____

Physician's Name: _____ Preferred Medical Facility: _____

Health Insurance: _____ Policy #: _____

Allergies to medication or other known allergies: _____

Current medications: _____

In the event of an emergency contact:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Consent Plan

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of Camp Moy Mo Da Yo.

I authorize Town of Limington employees to:

1. Secure and retain medical treatment and transportation if needed.
2. Release client records upon request to the authorized individual or agency involved in the emergency medical treatment.

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed life saving and medically necessary by the treating physician. This provision will only be invoked if the person (s) above is unable to be reached.

Date: _____ Consent Signature: _____
Parent or Legal Guardian

Non-Consent Plan

I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or being on the property of Camp Moy Mo Da Yo.

In the event emergency treatment/aid is required; I wish the following procedure to take place:

I have advanced directives and a copy of this is with: _____

Date: _____ Consent Signature: _____
Parent or Legal Guardian