Camp Good Days and Special Times

Date:___________________________

Event:__________________________

Time:___________________________

Has any information changed with your health insurance provider? No _____ If yes:____________________________

Child's name: ____ DOB: ________________________

Child's name: ____ DOB: ________________________

Child's name: ____ DOB: ________________________

Child's name: ____ DOB: ________________________

Home Address:____

Parent/Guardian Name: ____

Emergency Phone #'s: ____

I understand it is my responsibility as the parent/ guardian to inform CGD of any dietary restrictions, allergies and special needs of camper prior to this event:_______(Parent initials)
Please list any dietary restrictions, allergies or special needs pertaining to child:

____

____

Medications (please include any medication routinely taken, (including inhaler for asthma, over the counter and chemo):

Name	Dose	Route	Schedule

I hereby give permission for the above named child to participate in the stated activity, and agree to release Camp Good Days and Special Times, Inc. and everyone involved of all liability or claims associated with this event.

Parent/Guardian Signature: ____ Date: _______________

I hereby grant permission for the above named child to participate in any audio-visual event that may take place in accordance with their participation, and release Camp Good Days and Special Times, Inc. and everyone involved of any liability in association with media coverage, if such takes place. Also, I give permission for any photographs to be used for publicity to promote Camp Good Days & Special Times.

Parent/Guardian Signature: ____ Date: _______________

Emergency Medical Authorization
Purpose: to enable parents or guardians to authorize the provision of emergency treatment for children who become ill or injured while under Camp authority, when parents or guardians cannot be reached.
In the event that reasonable attempts to contact me (us) have been unsuccessful, I hereby grant consent to Camp Good Days for the administration of any treatment for my child deemed necessary by our physician.
If in the event that the designated preferred practitioner is not available, another licensed physician will be called. If hospitalization is necessary I request transfer of my child to ____________________Hospital or any hospital reasonably accessible. I also agree that in case of injury to my child requiring medical attention that my accident and hospitalization____________(name of Insurance) will be used to pay any expenses connected with injury.

Parent/ Guardian Signature:____ Date:_________________