

Camp Trinity Emergency Contacts Document

_____ Birthday __/__/__

Child's First Name _____ Child's Last Name _____

Address/City/Zip _____ / _____ / _____

1st Parent/Guardian Name _____ Email address _____

Cell Phone number: _____ Work number _____ Home number _____

2nd Parent/Guardian Name _____ Email address _____

Cell Phone number: _____ Work number _____ Home number _____

Other person to notify in case of an emergency

Name _____ relationship _____ phone # _____

Consent to medical care and treatment of minor child

I hereby give permission that my child, _____, may be given treatment by a qualified child care provider at Trinity Lutheran Child Development Center. When I cannot be contacted, I authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician, health care provider, hospital or emergency medical technician (EMT) when deemed necessary or advised by the physician or EMT to safeguard my child's health. I waive my right of informed consent to such treatment.

I give my permission for my child to be transported by ambulance or aid car to an emergency center for treatment.

Parent/Guardian signature

Date

Child's Health information, allergies, including drug reactions: