



Camp Hawkeye

TREATMENT CONSENT FORM

This form has been created to provide Camp Hawkeye with permission to provide, initiate, or approve health care and treatment, emergency or otherwise, for your child. This includes, but is not limited to; care provided by the Camp Nurse, Health Care Consultant, Local Pediatric Center and its affiliated or partner organizations, and Area Hospitals or other emergency or referred clinics. By signing this form you are giving consent for Camp Hawkeye and the healthcare organizations which it approves to treat your child during their time at camp.

Camper's Full Name _____

Date of Birth ____/____/____
Month Day Year

Parent/Guardian Contact Information

Parent/Guardian's Full Name(s) _____

Address _____

Phone (H) _____ (C) _____ (W) _____

Parent's E-Mail _____

Emergency Contact Information

Please provide the contact information for someone we may contact in an emergency if we are unable to reach you.

Emergency Contact Name(s) _____

Phone (H) _____ (C) _____ (W) _____

E-Mail _____

Insurance Information

Each camper **MUST** provide proof of insurance and include a copy of the front & back of his/her insurance card.

Primary Insurance Carrier _____ Phone _____

Billing Address _____

Primary Holder Name _____ Policy # _____

Signature: _____

Date: _____