



# 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: \_\_\_\_\_

[www.camphawkeye.com](http://www.camphawkeye.com)

Winter Address: 8 Hammer Street • Waltham, MA 02453 • Phone: (617) 960-6740 • Fax: (866) 615-1769  
Summer Address: 234 Red Hill Road • Moultonborough, NH 03254 • Phone: (603) 253-3088 • Fax: (866) 615-1769