CAMP ONE STEP BY CHILDREN'S ONCOLOGY SERVICES

Sibling Camp Medical Consent

PLEASE fill out ALL pages of the application COMPLETELY and PRINT CLEARLY

* * * * * **To be completed by the PARENT/GUARDIAN and returned with application.** * * * * *

Child's Name	First	MI	Last		
Gender	Male		Birth Date	Month	Day	Year

Parent/Guardian Information:			
Name		Relationship	
Home Number	( )	Work Number	( )
Cell Number	( )	Alternate Number	( )
E-mail			

Name		Relationship	
Home Number	( )	Work Number	( )
Cell Number	( )	Alternate Number	( )
E-mail			

Child lives with: Other Guardian

If parents are divorced, which parent has legal custody? Other Guardian

Emergency Contact (required): Person other than parent/guardian to contact in case parent/guardian cannot be reached.			
Name		Relationship	
Home Number	( )	Work Number	( )
Cell Number	( )	Alternate Number	( )

Medical Treatment Consent Information:	
To be used by medical staff and/or emergency room personnel. Please refer to the Medical Information Packet.	
I hereby grant permission for the medical staff to administer routine care, medications, and determine need for lab/x-ray studies for my child, as well as any emergency care required.	Please indicate choice: Yes

Parent/Guardian name (please print) _____

Parent/Guardian signature _____ _____

Date (Mo – Day – Yr)

*****This consent is valid for one (1) year from the date it was signed.*****

Primary Care Physician:

Office Address: _____

_____

_____

Telephone: ( ) _____ Emergency Phone: ( ) _____

Insurance Information:

*****Please note that a copy of BOTH sides of your health insurance, state Medicaid card and/or prescription card MUST be attached. If you are on Public Aid, be sure to copy your child's card.*****

Prescription coverage? Yes

Name of parent/guardian who insures child: _____

Birth Date of Primary Insured: _____

Date (Mo – Day – Yr)

* * * * * Application will **NOT** be processed without this form. * * * * *

*****This consent is valid for one (1) year from the date it was signed.*****