

CAMP MONROE
PO BOX 475
MONROE NY 10949
845-782-8695
845-782-2247 (FAX)

2010 CAMPER EMERGENCY CARE and TRIP FORM

LAST NAME _____

This form is to accompany the camper named on trips out of camp and/or for treatment in the event of an emergency.

FIRST NAME 1 _____ 2 _____ 3 _____

4 _____

BIRTHDATE 1 _____ 2 _____ 3 _____ 4 _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____ PHONE _____

MOTHER'S NAME _____ FATHER'S NAME _____

BUSINESS # _____ BUSINESS # _____

CELL # _____ CELL # _____

SS # _____ SS# _____

Name of person to be contacted in emergency if you cannot be reached.

NAME _____ PHONE _____ RELATIONSHIP _____

FAMILY DOCTOR & PHONE _____

FAMILY DENTIST & PHONE _____

CAMPER ALLERGIC TO _____

NAME OF INSURANCE COMPANY _____

NAME POLICY IS LISTED UNDER _____ DATE OF BIRTH _____

SOCIAL SECURITY # OF POLICY HOLDER _____ EMPLOYER OF POLICY HOLDER _____

POLICY OR GROUP NUMBER _____ If group, NAME OF GROUP _____

IT IS VERY IMPORTANT THAT WE HAVE A COPY OF YOUR MEDICAL INSURANCE CARD (front and back) as well as details about your company's filing procedure for any medical care: doctor, dentist, or hospital visit, prescriptions, etc. Include any insurance numbers we need. If your prescription plan is different, include a copy of your prescription plan card as well.

I hereby give permission and voluntarily consent to any of the emergency room physicians, qualified personnel, staff of any accredited hospital, or any duly licensed physician to administer anesthetics and perform such diagnostic treatment or medical or operative procedures, upon my above named child(ren) as may be deemed necessary. I fully understand this consent.

PARENT SIGNATURE _____

DATE SIGNED BEFORE ME ON _____

NOTARY SEAL

LAST
NAME