

TALBOT HOSPICE CHILDREN'S BEREAVEMENT CAMP 2019 Medical Permission Form
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Child's Name: _____
(PRINT)

Parent/Guardian's Name: _____
(PRINT)

Emergency Phone Number(s): _____ Alt Number: _____

HEALTH INSURANCE

Company Name: _____ Group/Policy Number: _____

CHILD'S PRIMARY PHYSICIAN

Name: _____ Phone Number: _____

Other Medical Professional Treating Child (If applicable)

Name: _____ Phone Number: _____

I verify that my child is in good health and is able to participate in all the normal activities of the Children's Bereavement Camp.

I give permission for the camp nurse to provide regularly scheduled daily medications to my child, with the necessary doctor's order for such medications.

I give permission for camp staff, the camp nurse and/or any other professional to treat minor injuries or abrasions that occur, and in the reasonable opinion of Talbot Hospice staff, do not require further medical treatment. I also give permission for further medical treatment in the event that my child should become ill or injured and, in the reasonable opinion of the Talbot Hospice staff, should require emergency medical care. I release Talbot Hospice and its affiliates, officers, agents, employees and volunteers from any and all claims, damages or injuries which might be sustained in connection with treatment provided my child.

I give permission for transport of my child, by a Talbot Hospice employee, volunteer, or any emergency personnel, to a necessary medical facility, should this need arise, and hereby release Hospice and its affiliates, officers, agents, employees and volunteers from any and all claims, damages or injuries which might be sustained in connection with transporting my child.

Parent/Guardian's Name: _____
(PRINT)

Parent/Guardian's Signature: _____

Date: _____

TALBOT HOSPICE CHILDREN'S BEREAVEMENT CAMP 2019
Medical Information Form

Child's Name _____ DOB: _____

Allergies (food, medicines, insects, plants, etc.)

Medication to be given during camp (name, dose, time)

A doctor's order MUST be provided in order for medication to be given by camp nurse.

Dietary Restrictions

Medical Problems or Injury

Mental Health/Emotional Issues

Activities your child may not be able to do and why

Any additional health/dietary information we should know about your child

Parent/Guardian's Name: _____
(PRINT)

Parent/Guardian's Signature: _____ Date: _____