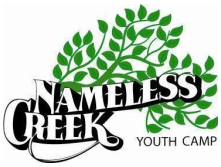

2025 Consent for Medical Treatment of a Minor Child

PLEASE EMAIL TO: pincampdirector@gmail.com

I (We), _____ and _____,
(parent/guardian) (parent/guardian)

residing at _____, _____
(address) (city)

_____ _____ of _____ County, do hereby
(state) (zip) (County Name)

state that I am (we are) the parent(s) or legal guardians of _____,
(student)

A minor of age _____, born on _____, who resides with me
(Student age) (student birthdate)

(us). I (We) authorize an adult volunteer or the camp director to administer minor first aid and to consent to any necessary examination, anesthetic, medical diagnosis, surgery or treatment and/or hospital care and transport to be rendered to the above named minor under the general or special supervision and on the advice of any physician or surgeon licensed to practice medicine in the state of Indiana.

Dated this _____ day of _____, __2025____.
(date) (month) (year)

_____ _____
(signature of parent or guardian) (signature of parent or guardian)

Medical Insurance Carrier :_____ Group # _____

ID # _____ Member's Name _____

2025 MEDICAL HISTORY FORM FOR TREATMENT OF MINORS

Last Name _____First Name_____Middle Initial _____

Date of Birth_____Place of Birth_____Sex: ☐M ☐ F

IN CASE OF EMERGENCY, PLEASE NOTIFY:

Name	Phone	Cell Phone	Relationship
1.			
2.			
3.			

ALLERGIES TO MEDICATION AND OTHER SUBSTANCES? ☐ Yes ☐No

☐ Penicillin ☐Sulfa ☐ Aspirin ☐Insect Stings ☐ Other (***explain below***)

_____

List any food allergies:_____

Medications

Please list medications taken on a regular basis: _____

_____

Please list medications that need to be taken during the camp day (9am-4pm) and how to administrator them:
_____

_____

**** Medication must come to camp in the original container and placed in a Ziploc bag labeled with the camper's name. They will be given to Camp Director****

MEDICAL HISTORY: Please check if your child has or has had, any of the diseases or conditions listed below:

☐ **Frequent Headaches**	☐ **Heart Problems**	☐ **Diabetes**	☐ **Asthma**
☐ **Seizures**	☐ **Hives**	☐ **Ear Problems**	☐ **High Blood Pressure**
☐ **Eye Problems** **If so, please explain.**	☐ **ADHD**	☐ **Autism**	☐ **Other: (explain)**

Does the camper use an inhaler and if so what type: _____

Permanent disabilities
(Describe/date):_____

Serious illness/injuries or surgery
(Describe/date):_____

Student may be given the following by an adult volunteer or Camp Director:

Aspirin ___ Ibuprofen___ Acetaminophen____ Pepto Bismol ____ Other _____

Does this student wear contact lenses? _____ Prescription Glasses? _____

Date of Last Tetanus Shot: _____ (we need to know if it is up to date)

Does your child have an I.E.P.? No____ Yes____ Indicate Eligibility_____

So that we may better serve your child's needs may we contact your child's school for additional information? No_____ Yes_____

School_____

Transportation and Contacts:
In order for a camper to be released from camp each day, the parents/guardians must specify what adult has consent to take the camper home. This adult must be listed below and have picture identification (i.e. driver's license) with them each day.

Name	Relationship to Camper

If questions or concerns should arise during the camp day, please list a primary and secondary contact along with phone numbers where you can be reached:

PRIMARY:_____ _____
Name Phone Number

SECONDARY:_____ _____
Name Phone Number

_____***Initials here if you prefer your child NOT to be included in any published pictures while at camp.***

****REMINDER: Please EMAIL to pincampdirector@gmail.com by due date or camper will not be officially registered!****