CAMPER
MEDICAL INSURANCE COMPANY

CAMPER'S NAME:

MEDICAL INSURANCE COMPANY NAME:

POLICY #:

IN AN EMERGENCY CONTACT:

NAME/RELATIONSHIP/PHONE NUMBER

IF PARENTS CANNOT BE REACHED, PLEASE NOTIFY:

NAME/RELATIONSHIP/PHONE NUMBER

FAMILY DOCTOR:

NAME/GROUP/PHONE NUMBER

KNOWN ALLERGIES/DRUG REACTIONS:

INSURANCE IS NOT PROVIDED BY SNU SCHOOL FOR CHILDREN.

I, THE UNDERSIGNED PARENT OR GUARDIAN, DO HEREBY AUTHORIZE THE CAMP DIRECTORS AT THE SNU CHILDREN TO SECURE ANY & ALL MEDICAL TREATMENT IN THE EVENT THAT I CANNOT BE CONTACTED. I FURTHER AUTHORIZE ANY ATTENDING PHYSICIAN TO RENDER ANY & ALL MEDICAL CARE WHICH HE OR SHE MAY DEEM NECESSARY.

IT IS UNDERSTOOD THAT, IN ANY EVENT, AN ATTEMPT WILL BE MADE TO CONTACT THE PARENT BEFORE TREATMENT IS STARTED. I, THE UNDERSIGNED PARENT OR GUARDIAN, UNDERSTAND THAT SOUTHERN NAZARENE UNIVERSITY SCHOOL FOR CHILDREN DOES NOT PROVIDE MEDICAL INSURANCE FOR MY CHILD.

PARENT OR GUARDIAN SIGNATURE