

Please attach a copy of your insurance card, both front and back.
Rock the River Camp 2009
INFORMATION/AUTHORIZATION FOR EMERGENCY MEDICAL CARE

NAME _____ BIRTH DATE _____

ADDRESS _____

HOME PHONE _____ GRADE ENTERING _____

T-SHIRT SIZE _____

MOTHER'S WORK # _____ FATHER'S WORK # _____

MOTHER'S CELL _____ FATHER'S CELL _____

HEALTH INSURANCE CARRIER _____

POLICY HOLDER'S NAME _____

POLICY # _____ GROUP # _____

ALLERGIC TO ANY MEDICATIONS? _____

FAMILY PHYSICIAN _____ PHONE _____

PARENTS' NAMES _____

ADDRESS (IF DIFFERENT FROM ABOVE) _____

IF UNABLE TO REACH PARENTS, IN CASE OF EMERGENCY, CONTACT:

I/We the undersigned parents or legal guardian of the child above do hereby authorize any x-ray, examination, anesthetic, dental, medical or surgical diagnosis or treatment by any physician or dentist and hospital service that may be rendered to said minor under the general or specific consent of a Katy Community Fellowship/Faith West staff member or representative.

I/We authorize the physician or dentist to call in any necessary consultant, at his/her discretion. It is understood that this consent is given in advance of any specific diagnosis or treatment being required, but is given to encourage those persons who have temporary custody of the minor, and said physician or dentist to exercise their best judgment as to the requirements of such diagnosis or medical, dental, or surgical treatment. This consent shall remain effective from Monday, July 27, 2009 through Friday, July 31, 2009. I further agree that if I should find legal action necessary against Katy Community Fellowship/Faith West for any reason, I will pursue such action through a bonded Christian arbitration service rather than a court of law. If the church or its agent not be found at fault, I agree to pay any fees, damages, or other costs incurred by such action.

Parent's Signature