

ARETE SWIM CAMP

CONSENT FOR TREATMENT OF A MINOR/INSURANCE INFORMATION

I, the undersigned, as the parent or legal guardian of a minor _____ hereby authorize the designated camp physician to perform such diagnostic, medical and/or surgical treatment on my child as may be deemed medically necessary in order to assure the safety of my child. It is distinctly agreed and understood that the medical personnel participating in the care of my child shall not be responsible in any way for any consequences resulting from said diagnostic, medical and/or surgical treatment and are fully released from any and all consequences of such treatment, diagnosis, or surgery, provided that these duties are performed with ordinary care and to the best of their ability.

Signature of Parent/Legal Guardian _____ Date _____

Print parent/guardian's name _____

In case of emergency, parent/guardian can be reached at: (H) _____ (W) _____ (C) _____

Name and Address of person responsible for medical bills: _____

I hereby acknowledge that the named minor child is covered by medical insurance as follows:

Insured _____ Company _____

Policy Number _____ Company Phone # _____

Signature of Parent or Legal Guardian _____ Date _____

**ARETE SWIM CAMP
PHYSICIAN'S AUTHORIZATION**

I hereby certify that I have examined (name of camper) _____

And found him/her physically fit to attend and participate in the Arete Swim Camp. I know of no impairments, which would limit his/her participation in all camp activities except those that I have listed below. I further certify that he/she is free from any and all contagious diseases.

Restrictions and/or comments: _____

Date of last tetanus immunization: _____

Date of exam: _____

Physician: _____ Phone: _____

Address: _____

Physician's Signature: _____ Date: _____

CAMPER NAME: _____ **SEX** _____ **AGE** _____ **SESSION DATES** _____
