

Online Medical Authorization Form

Camper Name: _____

Camper Address: _____

City/State/ZIP: _____

Parent/Guardian responsible for completing this form for the camper:

Print Name: _____

Signature: _____

Relationship to Camper: _____

Shirt size of camper: XSm SM Med LG | Toddler or Child

CAMP NAME **CAMP DATES** **HALF/FULL/EXTENDED DAY**

_____ half full EXT

_____ half full EXT

_____ half full EXT

_____ half full EXT

_____ half full EXT

_____ half full EXT

_____ half full EXT

_____ half full EXT

_____ half full EXT

Email address: _____

PHOTO RELEASE

I authorize Camp EdVenture to take and use, without payment, any photographs of my child as needed for public relations, marketing, advertising or internal training purposes.

Please circle one of the following: **YES** **NO**

AUTHORIZED CAMPER PICK-UP ADULTS

Please list the individuals authorized to pick up your child from camp:

A PHOTO ID WILL BE REQUIRED AT PICK-UP EACH DAY.

Name: _____ Relationship: _____

Phone: _____ Phone: _____

Name: _____ Relationship: _____

Phone: _____ Phone: _____

Name: _____ Relationship: _____

Phone: _____ Phone: _____

2009 Medical Authorization Form for Camp EdVenture

PLEASE CONTACT ME AT THE FOLLOWING NUMBERS IN CASE OF EMERGENCY

Work Phone: _____ Cell Phone: _____

Home Phone: _____ Other: _____

List two alternate people who can be contacted if your child becomes sick and we can not get in touch with you.

Name: _____

Relationship: _____ Phone: _____

Name: _____

Relationship: _____ Phone: _____

In the event reasonable attempts to contact me at the above phone numbers are unsuccessful, I give consent for the administration of any treatment necessary by:

Preferred Physician: _____ Phone: _____

Preferred Dentist: _____ Phone: _____

In the event my preferred practitioner is not available I authorize treatment by another licensed physician or dentist.

YES NO

In case the above emergency contacts can not be reached, I authorize transfer to:

Palmetto Health Richland Palmetto Health Baptist

Providence Hospital Lexington Medical Center

My child has the following: (Allergies to food medication environment etc.)

If your child has food allergies make sure you bring an alternate snack for your child. (Note: Food camps will have recipes that use nuts, fruit and dairy products.)

Activity restrictions: _____

List any other special needs your child has: _____

Return by mail: Camp EdVenture, 211 Gervais Street,
Columbia, SC 29201

Register by fax: 803-779-3144, Attn; Camp

Please return or fax this form so it is received 1 week prior to specific camp start date

Cancellations must be received no later than two weeks prior to your scheduled camp date to receive a refund (minus a \$50 non-refundable processing fee). No refund will be given for cancellations made less than two weeks prior to camp date. Camps must meet minimum enrollment numbers or will be cancelled or rescheduled. For more information, e-mail camp@edventure.org. Additional applications may be downloaded from www.edventure.org.