

AUTHORIZATION FOR MEDICAL TREATMENT

In the event that I cannot be reached to make arrangements for emergency medical attention, I authorize the staff of Shepherd Camp, The Episcopal Church of the Good Shepherd, to take my child to:

Name of Physician _____

Address _____ Phone _____

Or to (Hospital/Clinic) _____

Address _____ Phone _____

Known allergies to food/medication _____

Signature of Parent/Guardian

Date _____

Please list names and phone numbers of two people to contact if parents cannot be reached in case of an emergency:

_____ **Phone** _____

_____ **Phone** _____