Medical Consent to Treat Form

Adult Sponsor Responsible for this Minor:_____
Sponsor's Cell Phone Number:_____

C-O-N-N-E-C-T-E-D

Teen Prayer Conference @Camp Yorktown Bay
October 28-30, 2016

IMPORTANT MEDICAL HISTORY

Conditions that may need special attention: _____
_____
_____
_____

Medical Allergies:_____

Date of last Tetanus/booster:_____

Primary Care Physician:_____

EMERGENCY CONTACT INFO

Name:_____

Phone #1:_____ Phone #2:_____

E-mail:_____

Insurance Company:_____

ID#:_____ Group:_____

MUST INCLUDE A COPY OF THE FRONT AND BACK OF CARD

I, _____(print parent/guardian name),

give permission for emergency treatment of_____
at the hospital or any other appropriate treatment center in the case of illness or accident. I do not hold Camp Yorktown Bay or the Arkansas-Louisiana Conference of Seventh-day Adventists liable for such treatment or the cost of incurred tread.

Signature:_____ Date:_____
Parent/Guardian

Make Checks Payable to: Arkansas-Louisiana Conference.
Mail Payment AND Medical Consent to Treat form to:
Arkansas-Louisiana Conference, P.O. Box 31000, Shreveport, LA 71130