CONSENT TO MEDICAL TREATMENT

NAME OF CAMPER:				BIRTH DATE:		
NAME OF PARENT/GUARDIAN:				E-MAIL:		
HOME	E PHONE:	WORK PH	ONE:	CELL PHONE:		
HOME	E ADDRESS:	Street	City	State	Zip	
Pleas	e read and comple	ete the following:				
MU	ST be in its ORIGIN	IAL bottle. This shage, prescription nu	ould be labeled wi	th the camper's na	escription medication me, doctor's name, ons. Please check	
	No medication(s) will be brought to camp.					
	I want the medication to be self-administered (age 18 and above only).					
0	I want the medication administered by camp staff; however, a limited amount of medication for life-threatening conditions may be carried by my son/daughter (i.e. inhaler, insulin syringe, etc.					
I AGR	EE TO THE FOLL	OWING:				
•	 I am giving my consent in advance for medical treatment at an appropriate medical facility in case of illness or injury. 					
•	I am stating that I am aware of, and accept the risk inherent in program activity.					
•	I attest that all information I have provided on all forms is correct.					
•	I agree to hold harmless and indemnify Camp and Immanuel Lutheran College, their officers, facilities, agents, volunteers, and employees from any and all liability, loss, damages, costs, expenses which are sustained, incurred, or required arising out of the actions of my son, daughter, or ward in the course the camp.					

SIGNATURE OF PARENT OR LEGAL GUARDIAN

DATE