

**Creation Care Interfaith Arts Camp Consent Form 8/20/18 – 8/23/18**  
**Concordia Evangelical Lutheran Church Duluth, Minnesota**

Youth Name: \_\_\_\_\_  
                    first                                    last                                    initial                                    age                                    date of birth

Home Address: \_\_\_\_\_  
                    number & street                                    city                                    state                    zip                                    phone number

Parent/Guardian Name/s: \_\_\_\_\_  
  first  last

Home Address: \_\_\_\_\_  
                    number & street                                    city                                    state                                    phone number

Additional Phone numbers: \_\_\_\_\_  
  mother's work #                                    father's work #                                    cell phone #

Additional Emergency Contact Person: \_\_\_\_\_  
  name                                    relationship                                    phone number

**AUTHORIZATION FOR EMERGENCY TRANSPORTATION AND TREATMENT**

I do  do not  authorize an adult leader to transfer my son/daughter to a physician's office and/or emergency room in the event that emergency medical care is needed.

I do  do not  authorize an adult leader to treat my son/daughter as they deem necessary in the emergency situation.

Hospital Preference  Essentia  St. Lukes

Primary Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Name of medical insurance company: \_\_\_\_\_ Policy number of medical insurance: \_\_\_\_\_

Primary listed on the insurance policy: \_\_\_\_\_

Is your son/daughter presently taking any medication YES  NO

If yes, list medication/s: \_\_\_\_\_

Allergies (please list): \_\_\_\_\_

Dietary restrictions: \_\_\_\_\_

Signature of parent/guardian: \_\_\_\_\_ Date: \_\_\_\_\_

By signing this form, I give my son/daughter permission to engage in all camp related activities. In the event that I cannot be reached in an emergency, I hereby give my permission to the physician selected by the adult leader to secure proper treatment for my child as named above.

**\*\*Note: This authorization will allow your son/daughter to receive medical treatment in timely manner if he/she has a broken bone or other non-life threatening illness or injury AND you are not able to be contacted to authorize medical treatment for your child.**