2025 Consent to

Medical Treatment

Name of Student: _____ Birth Date: _____

Name of Parent/Guardian: _____ E-mail: _____

Cell Phone: _____ Other Phone: _____

Home Address: _____

Street City State Zip

Allergies: (please list all food, medication, insects, etc.) _____

Current Medications & Doses:_____

Please read and complete the following:

Camp director(s) and/or camp staff will administer all medication. All prescription medication MUST be in its ORIGINAL bottle. This should be labeled with the student's name, doctor's name, medication time, dosage, prescription number, date prescribed, and instructions. Please check what applies below:

- ☐ No medications will be brought to camp.
- ☐ I want the medication to be 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, etc.)

I agree to the following:

- 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 activities.
- I attest that all information I have provided on all forms is correct.
- In the case of injury or illness, I agree to hold harmless and indemnify Christ's Explorers Camp and Holy Trinity Evangelical Lutheran Church, 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 of camp.

Signature of Parent or Legal Guardian Date