

**CONSENT FOR EMERGENCY TREATMENT OF MINORS
IN ABSENCE OF PARENT(S) OR LEGAL GUARDIAN**

Name of Minor: _____ Age: _____ Birth date: _____

Address: _____

Home Phone: () _____ Cell: () _____

Parent/Legal Guardian (s) Name(s):

I, the undersigned, am one of the parents of the minor named above. I know that for the following reasons I may not be available to personally authorize medical, dental, surgical care and hospitalization for said minor. Those reasons are:

Child is under care of the staff at Camp Fish and Game, during the camp day. In case of an Emergency and the parent/guardian cannot be reached.

I hereby give my consent and authorization for any emergency or non-emergency diagnostic procedure, medical, dental, surgical care and hospitalization that any health care provider so determined as advisable, in the best judgment of said health care provider including, but not limited to, any physician, dentist or hospital personnel providing health care to the minor.

In my absence, I would like the health care provider to discuss the matter with the persons designated below. I authorize those persons, insofar as the law of New Jersey State permits me to do so, to enter in to the decision, to convey to the provider my consent, and to consent to said treatment.

I hereby authorize the health care provider to discuss in full with those persons designated any medical information that is required to help the input of the persons so designated.

I hereby hold harmless any physician, dentist, hospital or hospital personnel, or other health care provider rendering such care to the minor from any liability resulting from the failure to obtain consent from me as parent of the minor and from any other person. It is my intent that the person or persons appointed herein shall be able to act in my stead in making such decisions.

I have put the important medical facts, if any, on the Universal Health Form and Camp Fish and Game Application, provided to the Camp. The medical facts are intended to help a doctor, medical personnel, or other health care provider in deciding what treatment is to be given but is in no way intended to restrict the authorization and consent hereby given.

I hereby appoint one person from the following list (on the next page) to be chosen in the order of priority listed when the persons in the prior listings are not reasonably available, willing or competent to participate in the health care decision-making concerning the minor:

Names, Addresses and Phone Numbers of those persons I am so authorizing are as follows:

CHILD'S EMERGENCY CONTACT

Name: _____ Address: _____
Phone: _____

ADDITIONAL NAME:

Name: Sloane Lipson, F&G Camp Director Address: 41 Fairmount Avenue. Chatham, NJ 07928
Phone: 610-223-7755

The period of time over which this authorization exists is as follows:

Beginning at 12 midnight on: _____
Month Day Year
Ending at 12 midnight on: _____
Month Day Year

It is intended that this document shall be presented to the physician, dentist, or appropriate hospital or medical representative at such time that the medical, dental, surgical care or hospitalization shall be authorized.

It is intended that this authorization relieve the physician, dentist, or any health care provider or any hospital or institution in which such care is given from any liability resulting from the failure of me, as parent, or any other person, from signing a consent or authorization to render such care. It is the intent that the person or persons appointed herein shall be able to act in my stead in making decisions.

_____ Signature of Parent/Legal Guardian	_____ Date	_____ Signature of Parent/LegalGuardian	_____ Date
_____ Address		_____ Address	
_____ City/State	_____ Zip	_____ City/State	_____ Zip
_____ Home Phone	_____ Cell Phone	_____ Home Phone	_____ Cell Phone

For information only, I am listing said minor's usual dentists and doctors so they may be consulted if that is deemed necessary by anyone: _____

