EMERGENCY TREATMENT FORM

Date: ________________

No individual can be accepted as a camp participant until this form has been completed by his/her parent(s) or guardian or by the individual if he/she is a legally competent adult age 18 or over. Campers will be under strict supervision, and although every effort will be made to avoid any accident, **no liability** can be accepted by any of the individuals or organizations concerned or by Wexford County MSU Extension, the Wexford County 4-H Leaders Association, its personnel, or affiliates. Completion of this form constitutes parent/guardian permission for the named individual to participate in the program.

Name ____ Date of Birth ______________________

Address ____ City ____________________ State _____ Zip ___________

Home Phone (___)________________________________ Work Phone (___)_________________________________

Parent/Guardian Name (if under 18 years) _________________________________ Phone (___)_________________

Address ____ City ___________________ State _____ Zip ____________

Physician's Name ____ Phone (___)________________

Address _______________________________________ City _____________________ State ______ Zip __________

Is there a medical condition requiring special precaution or treatment? Yes 9 No 9

If yes, please describe ____

Medications being used? Yes 9 No 9 If yes, please list dosage and description _______________________________

Person who should be notified in case of emergency in absence of parent or guardian:

Name _______________________________________ Phone (___)______________ Relationship _________________

AUTHORIZATION FOR PURPOSE OF PROVIDING MEDICAL TREATMENT

You are being asked to complete this form to give an appropriate medical facility permission to treat ______________________ (volunteer's name) for minor injury or medical problems. In the event of serious injury or illness, the parent/guardian listed above, will be contacted; treatment will proceed before contacting them only if the situation is urgent and does not permit delay.

Preferred Medical Facility: ____

In case of medical emergency, the undersigned authorizes the Michigan 4-H Proud Equestrians Program instructor and/or program coordinator to seek any medical and/or surgical treatment necessary for the care of ___________________ who is participating as a volunteer in the 4-Hproud equestrian Program with parent/guardian permission (if under 18 years). I understand that **no liability** can be accepted by any individual or organization concerned with this program in the event of any accident which may occur.

Health Insurance Information:

Name of Policyholder ____

Name if Insurance company _______________________________________ Policy Number _____________________

If you have HMO/PHP Insurance, list the emergency phone number for treatment authorization (___)____________

The above designated person(s) is (are) hereby authorized to incur medical costs necessary to provide medical treatment for said participant for which we shall be fully responsible. We also authorize the medical facility to release any and all information required to complete insurance claims and also authorize insurance payment directly to the medical facility.

Volunteer, Parent or Guardian (circle one) Signature _________________________________ Date _____________

Witness ____ Date ______________