



**Funutation Tekademy LLC  MEDICAL RELEASE FORM**

Child's Name: \_\_\_\_\_ Gender M F Birthdate: \_\_\_\_\_

Age: \_\_\_\_\_ School: \_\_\_\_\_

Phone: \_\_\_\_\_

**EMERGENCY MEDICAL AUTHORIZATION - 2009**

Funutation Camps is not responsible for any injury that may occur during the camps

**GRANT OF CONSENT**

In the event of an emergency please contact:

Parent/Guardian: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Relative/Friend: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

If none of these contacts are available, I authorize administration of any necessary treatment by the following:

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

Please list any facts about the child's medical history (medications, allergies, physical impairments, etc):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

In the event that reasonable attempts to contact me have been unsuccessful, I hereby give consent for:

(1) the administration of any treatment deemed necessary by the above named doctors, or, in the event that the preferred practitioner is not available, by another licensed physician or dentist and

(2) the transfer of my child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

**Signature of Parent/Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

**REFUSAL OF CONSENT (not needed if you completed the above)**

I do not consent for emergency medical treatment of my child. In the event of an illness or injury that requires medical attention, I wish Funutation Camps to TAKE NO ACTION.

**Parent/Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_