Exploring the Arts
Huron County

CONSENT FOR MEDICAL TREATMENT
OF A MINOR CHILD

NAME OF EVENT: Exploring the Arts-Huron County Camp 2024 **Dates of Event:** _____ August 5 - 9, 2024
OR ______ August 12 - 16, 2024

CHILD'S FIRST NAME: ____________________ Birth Date: ______________ Age: ___________

Parent/Guardian #1: Name ________________________ Address: ________________________________

Phone: Home __________________ Cell _________________ Work _________________

Parent/Guardian #:2 Name ________________________ Address: ________________________________

Phone: Home __________________ Cell _________________ Work _________________

Alternate Contact : Name ________________________ Address: __________________________

Phone: Home __________________ Cell _________________ Work _________________

MEDICAL INFORMATION: Physician Name & Phone Number: ______________________________________

Allergies to medications: ____

ALLERGIES (other, including food); please specify: ____

____

If applicable, please note the conditions for which the child is currently receiving treatment or medication:

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If your child is required to take medications prescribed by a physician during the course of this event, and you wish Exploring the Arts – Huron County personnel to assist your child in taking this medication, please indicate by signing below. In addition, please state the type of medication and provide a statement from the child's physician detailing the method, amount and time schedules by which such medication is to be taken.

Medication: ____

Physician statement attached: Yes ___________ No _________

In the case that I desire my child to apply sunscreen or insect repellant, I agree to supply said materials to Exploring the Arts – Huron County labeled with my child's name and application instructions. Exploring the Arts – Huron County camp personnel cannot apply these materials but will supervise the application by the child.

By Signing my name in the space below, I represent that I have legal custody of the above-mentioned child.

Name (s) Parent/Guardian: ____

NOTE ANY OTHER SPECIAL CONSIDERATIONS REGARDING YOUR CHILD: _______________________________

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AUTHORIZATION AND CONSENT OF PARENT(S)/LEGAL GUARADIAN: I grant authorization and consent for Exploring the Arts – Huron County to administer general first aid treatment for any minor injuries or illnesses experienced by the minor.

In case of serious accident or serious illness, I request Exploring the Arts – Huron County to contact me prior to rendering treatment to the patient. If the Exploring the Arts – Huron County is unable to reach me, I hereby authorize the Exploring the Arts – Huron County, to summon any and all professional emergency personnel to attend, transport, and treat the minor and to issue consent for any medical diagnosis, treatment or hospital care deemed advisable by, and to be rendered under the general supervision of any licensed physician, surgeon, dentist, hospital, or other medical professional or institution. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care but is given to provide authority and power to render care which medical or emergency personnel may deem advisable.

I agree to be financially responsible for any costs or expenses which are incurred in the above. I agree that any disclosure or use of any protected health information for my child pursuant to statements made or actions taken in accordance with this form shall not be violations of the federally protected rights under the HIPAA Privacy Rule, and I knowingly waive such privacy for these purposes.

By signing my name in the space below, I represent that I have legal custody of the above-mentioned child.

Name(s) of Parent or Guardian: ____

Date: ___________________________________