**Medical Release Form - Dakota Baptist Convention Youth Camp – 2019**

*Please attach a photo copy of your Health Insurance Carrier with the policy number.*

Church Attending with:

Camper’s Name (First, M.I., Last):

Address:

City:       State:    Zip:

Birth Date:       [ ] Male [ ] Female Phone:

T-shirt Size: Adult -

Parent/Guardian Name:

Emergency contact:

 Name:

 Phone:

Immunizations to date: [ ] Yes [ ] No [ ] Don’t immunize

Please list all allergies:

Medications needed during camp:

**Limited Power of Attorney: Consent to treat a minor only-**

**I give my permission/power to staff members or adult volunteers of the Dakota Baptist Convention Youth Camp for all emergency treatment and medical care of First, Middle Initial, Last that is necessary or desirable by the child’s attending physician. I give my permission to the staff at the Dakota Baptist Convention Youth Camp to treat minor injuries and dispense medicine. A registered nurse will be on duty at all times during the week of camp. I permit my child to attend the camp and participate in its activities. I agree that the Dakota Baptist Convention, a non-profit corporation, its officers, staff, employees and volunteers will not be liable for injuries, death, damage or loss to my child.**

**I have read and understand the terms of this agreement and am the parent/guardian of First, Middle Initial, Last.**



Parent/Guardian Signature Date

*(you can print & sign or take a photo of your signature and insert as a picture)*



Witness Date

*(you can print & sign or take a photo of your signature and insert as a picture)*