PERMISSION To Attend CPaYM's Camp
Xtreme Escape Camp ~ January 3-5, 2020

Name______________________________________ School____

Address_____________________________City______________State____Zip_____________

Date of Birth _________________ Grade______ Age______ Sex____

HEALTH INSURANCE COMPANY:____

GROUP NUMBER_______________________ POLICY NUMBER_________________

I, ____________________________ *(signature), (print name)*_______________________ ,
the legal parent/guardian of ________________________________,*do hereby release Central Pennsylvania Youth Ministries from any and all liability in case of accident or illness and authorize any medical care deemed necessary by an accredited physician, nurse or hospital while attending above mentioned function. I hereby assume all responsibility for his/her conduct, and for any damage my teen does to the camp property or any property of Central PA Youth Ministries, with the understanding that I will pay all damages. Any violation of the Code of Conduct will mean that I must provide immediate transportation home for my son or daughter. The use or possession of alcohol, illegal drugs any sexual conduct that is illegal, cigarette smoking and the use of smokeless tobacco, a failure to refrain from inappropriate touching and any form of verbal and physical harassment by my child will be a violation of CPAYM's code of conduct.*

I permit *Central PA Youth Ministries to use photographs of my child in publications and publicity material, and for inclusion in the Central PA Youth Ministries image library.*

I request *the camp nurse to administer the following medications to my child while attending this camp, if I have provided the appropriate paper work. I understand that a signed medical order form from the prescribing doctor must accompany each prescription. (see form on back). I have attached all necessary paper work.*

I request the following over the counter medications be given by the camp nurse. (check those medications your child may receive). ( ) acetaminophen ( )Tums/Rolaids ( ) Caladryl Lotion ( ) ibuprofen ( ) other list________________

My child has the following allergies/medical conditions that may require emergency medication: ___________
____

YOUR SIGNATURE MUST BE NOTARIZED. This will make it possible for us to secure medical treatment if necessary.

SUBSCRIBED AND SWORN TO BEFORE ME THIS ____________

DAY OF _______________________________20_____ (SEAL) ______

____
NOTARY PUBLIC

PHONE # WHERE I CAN BE REACHED_____________________________________

PLEASE SEND THIS FORM TO:
CENTRAL PENNSYLVANIA YOUTH MINISTRIES, PO BOX 189, SHAMOKIN DAM, PA 17876

Attention Parents:

The Medical Form only needs to be completed if your child has prescription medication that he/she will need to take during CPaYM Camps.

This form MUST be signed by the attending Health Care Provider.

Student Name ______________________________ **Club Leader Name ________________________**

CPAYM personnel may only administer medication prescribed by a qualified health care provider.
HEALTH CARE PROVIDER'S AUTHORIZATION

Student's Name ______________________________________

Medication 1 _________________________________ Dosage ________ Frequency __________
Possible Side Effects ____
Restrictions ____
Medication 2 _________________________________ Dosage ________ Frequency __________
Possible Side Effects ____
Restrictions ____
Medication 3 _________________________________ Dosage ________ Frequency __________
Possible Side Effects ____
Restrictions ____
Inhaler or Epinephrine auto injector: Student is authorized to carry and self administer? Yes___ No____

Health Care Provider Signature____
Health Care Provider print your name here ____
Date ___________________________ Telephone No. _________________________________

I (print parent/guardian name) ____
(signature) ____, request my child is to receive the above medication as prescribed, and I release CPAYM of all responsibility for any benefit and any and all adverse consequences of the medication. I also give consent for the CPAYM Staff to communicate with the above Health Care Provider for the benefit of my child.

CPAYM personnel may only administer medication prescribed by a qualified health care provider.
HEALTH CARE PROVIDER'S AUTHORIZATION

Student's Name ______________________________________

Medication 1 _________________________________ Dosage ________ Frequency __________
Possible Side Effects ____
Restrictions ____
Medication 2 _________________________________ Dosage ________ Frequency __________
Possible Side Effects ____
Restrictions ____
Medication 3 _________________________________ Dosage ________ Frequency __________
Possible Side Effects ____
Restrictions ____
Inhaler or Epinephrine auto injector: Student is authorized to carry and self administer? Yes___ No____

Health Care Provider Signature____
Health Care Provider print your name here ____
Date ___________________________ Telephone No. _________________________________

I (print parent/guardian name) ____
(signature) ____, request my child is to receive the above medication as prescribed, and I release CPAYM of all responsibility for any benefit and any and all adverse consequences of the medication. I also give consent for the CPAYM Staff to communicate with the above Health Care Provider for the benefit of my child. not picked up at the end of the school year will be discarded.