

**Temple Beth Rishon Camp Little Feet
Parent Medical Authorization Release Form**

**This form must be completed and returned before your child begins
camp. Thank you.**

Child's Name _____

1. I hereby give permission to the director and/or assigned designee to secure treatment for my child in the event I cannot be reached in an emergency. This includes transportation to the nearest hospital (Valley Hospital), and hospitalization.

2. If it is deemed necessary by my child's health care provider, I will provide the classroom teachers and/or the Director with an epi-pen, in its original container. It must be accompanied by a doctor's note and specific instructions for administration. These are to be used in emergency situations only. I understand that medications for non-life threatening illness will not be administered by school staff.

3. The following is my health insurance information, to be used to treat my child in case of an emergency, in the event I(or designated emergency contact) cannot be reached:

Health Insurance provider:

ID number:

Name of the person on the policy:

Parent signature: _____

Date: _____