**PLEASE RETURN COMPLETED FORM TO CAMP COCH**



**Emergency Medical Consent**

I accept complete responsibility for the health of the Participant and will not allow him/her to participate in the activity above unless, to the best of my knowledge, he/she is in good health. In case of medical emergency, I give permission to the Town of Goshen Recreation Department and its agents and employees to seek proper medical treatment, including hospitalization, and to authorize injection, anesthesia or surgery for the Participant if deemed necessary by a licensed or certified healthcare provider.

**Signed:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Parent/Guardian)

**BELOW TO BE COMPLETED BY SPECIFIED MEDICAL PRACTITIONER:**





* Does the patient have **allergies**? YES NO **Epipen?** YES NO
  + If yes, specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Is the patient on a **special diet**? YES NO
  + If yes, specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This patient is up-to-date on all the following routine childhood immunizations currently recommend by the American Academy of Pediatrics and National Advisory Committee on Immunization Practices:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | YES | NO |  | YES | NO |
| Measles |  |  | Hepatitis B |  |  |
| Mumps |  |  | Diphtheria |  |  |
| Rubella |  |  | Pertussis |  |  |
| Chickenpox |  |  | Pneumococcal conjugate |  |  |
| Tetanus |  |  | Polio |  |  |

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name of Medical Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Care Provider’s Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Care Provider’s City/Town, State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_