

# Bay Path Summer Program

## EMERGENCY RELEASE FORM

All questions must be answered. Please complete and return with application form.

Child's Name: _____	Birth Date: _____
Mother / Guardian Name: _____	Father / Guardian Name: _____
Address: _____	Address: _____
_____	_____
City: _____	City: _____
State: _____ Zip: _____	State: _____ Zip: _____
Home Telephone: _____	Home Telephone: _____
Work Telephone: _____	Work Telephone: _____
Cellular Phone: _____	Cellular Telephone: _____
Email: _____	Email: _____

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Person (other than parent) to call in case of emergency: _____	
Relationship: _____	Telephone: _____
Do you carry medical / hospital insurance? _____	If yes, name of carrier: _____
Policy / Group Number: _____	Subscriber: _____

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Name of family physician: _____	Hospital Preference: _____
Address: _____	City: _____
State: _____ Zip: _____	Telephone: _____

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Name of dentist / orthodontist: _____	Telephone: _____
Address: _____	_____
City: _____	State: _____ Zip: _____

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List any chronic or recurring medical conditions: \_\_\_\_\_

List any dietary restrictions: \_\_\_\_\_

List any medication currently being taken by the camper for any condition: \_\_\_\_\_

\_\_\_\_\_

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**Medical Emergency Agreement:** In case of a medical emergency involving my child / ward, I understand that every effort will be made to contact me or other parent / guardian / alternate person. In the event that I or they cannot be reached, I hereby give permission to the physician selected by the Bay Path Administration to hospitalize, to secure proper treatment for, and to order injection, anesthesia, surgery, or other medical procedures necessary for my child.

Signature of Parent / Guardian: \_\_\_\_\_ Date: \_\_\_\_\_