2018 Medical Release Form

Physical Address:
50 CR 1207
Maud, TX 75567
903-585-3435*
** - Camp number, please use for emergencies only*

Mailing Address:
PO Box 465
Mt. Vernon, TX 75457
903-537-4129

Child's Name: _____ Date of Birth: _____ Gender: _____

Session(s) Planning to Attend:

- ☐First Session - June 3-8 – Director: Allen Chance
- ☐Second Session - June 10-15 – Director: Ross Haffner
- ☐Third Session - June 17-22 – Director: Jon McCormack
- ☐Fourth Session - June 24-29 – Director: JJ Hendrix; Leadership Session
- ☐Fifth Session - July 1-6 – Director: Bryan Braswell

I hereby give Camp Ida permission to take my child to any hospital facility or outside doctor when deemed necessary.

Furthermore, I hereby give permission to such hospital or outside doctor to authorize x-rays and emergency treatment if deemed necessary. I understand that all medical bills for service rendered by anyone other than the camp's medical staff are my responsibility. I authorize the release of any medical information or records related to treatment, referral, billing or insurance purposes related to my child. A copy of this document may be accepted in lieu of the original. I have read the Medical Permission Statement above and understand its terms and accept its conditions.

Parent's Signature: _____ **Date**: _____

Parent's Name (Printed): _____ **Contact Number:** _____