2011 HEALTH & POWER OF ATTORNEY FORM

Name	Birth Date	( ) M ( ) F

Address	City	State	Zip

Camp Attending	Dates	Grade in Fall

Mother's (Guardian's) Name	Father's (Guardian's) Name
Address if different than above	Address if different than above
Home: (________) ______________________________ Work: (________) ______________________________ Cell: (________) ______________________________	Home: (________) ______________________________ Work: (________) ______________________________ Cell: (________) ______________________________

Other Emergency Contact	Phone
Physician Name	Phone

Insurance Company & Policy #

IMMUNIZATIONS	ALLERGIES / CONDITIONS		ILLNESSES
❑ Diphtheria ❑ Whooping Cough ❑ Polio ❑ MMR ❑ Tetanus date:	❑ Asthma ❑ Epilepsy ❑ Heart ❑ Diabetes ❑ Recent Surgery:	❑ Fainting ❑ Seizures ❑ Sleepwalking ❑ Allergies:	In the last two weeks: ❑ Flu ❑ Sore Throat ❑ Chicken Pox ❑ Other:

Other precautions, medical conditions, or medications (with directions):

LIMITED POWER OF ATTORNEY: CONSENT OF TREATMENT OF MINOR AND RELEASE OF LIABILITY

1. I/We, the undersigned, hereby appoint Kirkwood Ministries, Inc. and each of its authorized agents, each to act alone, and to delegate to the same power to consent on our behalf to all emergency treatment and/or any medical care (except elective surgery) of ______________________________ determined to be necessary or desirable by our child's attending physician at the hospital in which emergency treatment and/or medical care is sought.
2. I/We, the undersigned, give permission to Kirkwood Ministries, Inc. and each of its authorized agents to administer over-the-counter medication to ______________________________ should this be deemed necessary. Additionally, all physician–prescribed medications will be dispensed to the camper only if the prescription is contained in its original prescription bottle and only for the exact dosage prescribed on the bottle by the physician.
3. This Power of Attorney shall continue until revoked by the undersigned, or for one (1) year after its date, whichever is earlier. The attending physician(s) or the attending hospital's medical staff may assume and rely that this authorization is currently in effect during such one (1) year unless notified.
4. I/We, the undersigned, release Kirkwood Ministries, Inc. and any of its authorized agents from any obligation or liability, actual or implied, concerning their use of the limited purpose power of attorney.
5. The undersigned certify that they have read the Power of Attorney and Release of Liability Form (or had it read to them) and that they understand the same.

Parent/or Legal Guardian's Signature ____ Date: ________________________

Witness' Signature ____ Date: ________________________

Witness' Address: ______________________________ City _____________________ State _________ Zip _______________

Witness' Home Phone: ______________________ Night: __________________________ Other: __________________________