

**Dickson County Mission Camp  
Medical Release Form**

Name \_\_\_\_\_

Complete Address \_\_\_\_\_

Parent's Name(s) \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

In case parents cannot be reached, in the event of an emergency contact:

Name \_\_\_\_\_ Phone # \_\_\_\_\_

**WE MUST HAVE YOUR FAMILY'S MEDICAL/HOSPITAL INSURANCE INFORMATION:**

Carrier: \_\_\_\_\_ Policy Group # \_\_\_\_\_

1. Do you have any allergies such as, poison ivy, poison oak, bee stings, or are you allergic to any medications?
2. Do you have any special dietary requirements due to health issues?
3. Are you currently receiving any regular medications? If so, please list what kind and what for. \_\_\_\_\_
4. Are you currently under a physician's care? If so, describe: \_\_\_\_\_
5. Are there any other medical or special needs that might occur while you are at our camp?

**PARENT'S AUTHORIZATION:** The person herein described has permission to engage in all prescribed work camp activities except as noted by me or a physician. I hereby give permission to the physician selected by the Dickson County Youth Mission Camp directors to order x-rays, routine tests, and treatment for the health of my child in the event I cannot be reached in an emergency.

I hereby give permission to the physician selected by the Dickson County Youth Mission Work Camp to hospitalize, secure proper treatment for, and to order injections and/or surgery for my child as named above.

Parent's Signature \_\_\_\_\_

Date \_\_\_\_\_