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Camp Friendship Parent's/Guardian's Medical Authorization

This health history is correct so far as I know, and I, _____ give my full consent for the applicant _____ to attend Spina Bifida of Louisiana Summer Camp and to engage in all prescribed camp activities, except as noted by me.

In consideration of participation in the program and for the general purposes of the camp specifically including, but not limited to, the community service afforded by the availability of the program to children with disabilities, I agree to indemnify and hold harmless SB La from and against any injury or loss which my child may suffer arising out of or related to the following:

1. In the event I cannot be reached in an EMERGENCY, I hereby give permission to the physician selected by the Camp Director to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for my child as named above;
2. The administration of physician prescribed medication. Prescribed medication will be administered ONLY if the medication is in its original container labeled with the physician's instructions for its use accompanied by a written statement by the child's parent or guardian as to the time of day the specific (please state name of) medication is to be given;
3. The catheterization of a child will be carried out by non-professional but medically trained camp personnel ONLY with written instructions by the child's parent or guardian as to the time of such needed catheterization;
4. Travel to and from camp and during the camp day in transportation vehicles provided by SB La; and
5. Camp activities, including but not limited to swimming and fieldtrips. Children are not allowed to swim if they have a communicable disease, open sore or infection. Please advise the camp director of your child's current medical condition during the camp week. The camp director and/or camp staff will make the final determination whether a child may swim or otherwise participate in activities.

Permission is given for camper to receive first aid for minor injuries, administration of prescription medications according to physician's orders and emergency care/transport for life threatening conditions. In addition, permission is granted to SB La to photograph, videotape or record my child _____ for the purpose of the media or for SB La publications.

Child's Name: _____

Parent/Guardian Name _____ Parent/Guardian Signature _____

Emergency Contact Name/Relationship: _____

Emergency number(s): _____

Community Health Charites of La. #58675
United Way of Greater New Orleans #3174