

## Authorization of for medical treatment persons over 21

I, \_\_\_\_\_do hereby authorize Camp Duffield Staff to sign for any medical treatment deemed necessary for myself. My date of birth is\_\_\_\_\_.

This authorization is valid from \_\_\_\_\_(date) through and including \_\_\_\_\_(date).

Today's Date\_\_\_\_\_

Name\_\_\_\_\_ Print

Name\_\_\_\_\_ Signature

The person herein described has appeared before me and is known by me or has presented sufficient identification to prove that he or she is, indeed, the above individual.

Date\_\_\_\_\_

Notary Public Signature/Stamp\_\_\_\_\_

Health Insurance Company\_\_\_\_\_

Identification Number\_\_\_\_\_ Group No.\_\_\_\_\_

Place of Employment\_\_\_\_\_

### Provide a photocopy of insurance card

Camper Physician:\_\_\_\_\_ Phone\_\_\_\_\_

Camper Dentist/Orthodontist:\_\_\_\_\_ Phone\_\_\_\_\_

This form should be presented by responsible party at time of treatment.