



CAMP CLEAR LAKE – MEDICAL CONSENT FORM

I, _____ parents or legal guardians of _____, born the ____ day of _____ grant explicit permission for Camp Clear Lake/CLCCA to seek necessary medical care for my child _____. I consent to any medical care and the administration of anesthesia determined by a physician to be necessary for the welfare of my child.

This authorization is effective from the ____ day of _____, 2026 to
The ____ day of _____ 2026.

Signature of Parent or Legal Guardian Date

This consent form should be taken with the child to the hospital or physician's office when the child is taken for treatment. This additional information will assist in treatment if it can be furnished with the consent but is not required.

Family Address: _____

Parent/Guardian Telephone: _____

Last Tetanus: _____

Special Medications, Blood Type or Pertinent Information: _____

Child's Physician: _____ Phone#: _____

Insurance: _____ Policy#: _____

Preferred Hospital: _____

Check this box if you DO NOT have medical insurance for your child _____.

I, parent or legal guardian _____ (printed name) understand that I am fully responsible for all emergency and medical expenses incurred and will not hold Camp Clear Lake/CLCCA responsible. Therefore, Camp Clear Lake/CLCCA will not be held responsible in paying any emergency or medical expenses incurred.

Signature Date: _____

Printed Name