



Camp Hawkeye

TREATMENT CONSENT FORM

This form has been created to provide Camp Hawkeye with permission to provide, initiate, or approve health care and treatment, emergency or otherwise, for your child. This includes, but is not limited to; care provided by the Camp Nurse, Health Care Consultant, Local Pediatric Center and its affiliated or partner organizations, and Area Hospitals or other emergency or referred clinics. By signing this form you are giving consent for Camp Hawkeye and the healthcare organizations which it approves to treat your child during their time at camp.

This consent form will apply until one week after the close of camp. Thank you!

CiT's Full Name _____ Number of Years attending Hawkeye _____

Male Female Height _____ Weight _____ Date of Birth ____/____/____
Month Day Year

Parent/Guardian Contact Information

Parent/Guardian's Full Name(s) _____
Street _____ Apartment # _____
City _____ State _____ Zip _____
Phone (H) _____ (C) _____ (W) _____
Parent's E-Mail _____

Insurance Information

Each camper MUST provide proof of insurance and include a copy of the front & back of his/her insurance card.

Primary Insurance Carrier _____ Phone _____
Billing Address _____
Primary Holder Name _____ Policy # _____

Parent/Guardian's Name: _____
(Please Print)

Signature: _____ Date: _____

www.camphawkeye.com