GRAND VIEW HOSPITAL Sellersville, PA

Date:		
TI 1		
	ncy Room at Grand View Hospital, Sellersville, PA to treat my son/daugh	
named:	while a camper at Camp:	
from (Starting date):	to (Ending date):	
rash such as impetigo, poison oak or iv	average camp emergency such as sprain, cut, bruise, scrape, bump, skin y, bites such as bee sting and snake bites, allergic reactions, foreign bodies, pink eye, minor burns, fevers, diagnostic x-rays, auturing and the like.	
	significance such as fracture, an appendectomy, or any illness or injury ital that additional consents will be necessary for treatment and that the and reach me.	
My child is allergic to the following dr	ıgs:	
I also give permission for my child to r	eceive a tetanus booster if needed. His/Her last tetanus immunization was	;
(Date):		
Authorization is hereby given to my In any information needed to complete the	surance Company: to provide hospitalization claim.	
	ute emergency when hospital personnel have attempted to notify me and a form will suffice for treatment until such time as I am able to be reached.	
Parent Name (print):		
Parent Signature:		
Home Phone:		
Work Phone:		
Cell Phone:		