



**PERMISSION, HEALTH AND MEDIA FORM**  
for  
**Summer Farm & Science Camp**

*Please Print*

**Participant Information**      Date of Session \_\_\_\_\_

**Please complete one form for each child.**

Name of Child \_\_\_\_\_ Age \_\_\_\_\_ Gender M/F \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone - Day \_\_\_\_\_ Cell \_\_\_\_\_

Email \_\_\_\_\_

Secondary Emergency Contact: \_\_\_\_\_ Phone (day) \_\_\_\_\_

I do hereby grant my permission for the above named child to participate in The Summer Farm & Science Camp at Crown Point the summer of 2014. I assume all risks in connection with the program and release the board and staff at Crown Point, the Dominican Sisters of Peace and all volunteers thereof from all liability. My child will follow the rules for safety and conduct at Crown Point and direction of program staff.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

**Health Information**

Name of Parent/Guardian carrying Health Insurance \_\_\_\_\_

SS# \_\_\_\_\_ Insurance Company \_\_\_\_\_

Policy Number \_\_\_\_\_ and Group Number \_\_\_\_\_

Allergies \_\_\_\_\_

Any health issues and/or physical limitations \_\_\_\_\_

Current Medications, if any \_\_\_\_\_

I hereby give permission to the medical personnel selected by Crown Point to order x-rays, routine tests and necessary transportation for my child. In the event I cannot be reached in an emergency I hereby give permission to the physician selected by the Crown Point staff to secure and administer treatment including hospitalization for my child as named above.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

**Photo/Media Consent**

I do hereby give permission to use photographs and statements made by my child for Crown Point publicity and program promotions unless otherwise noted.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date