

UPWARD Sports Camp



Bethel Baptist Church

855 Brotherton Road, Escondido
(760) 745-4995 www.bbcesc.org

A Basketball and Cheerleading camp will be held

July 13-16 9 A.M. - Noon

for students who have completed Kindergarten thru 5th Grade.

It's FREE!!!!

Fill out the registration form and bring it with you to the first day of camp.

EVERY CHILD PLAYS! EVERY CHILD LEARNS! EVERY CHILD IS A WINNER!

Bethel Baptist Church
Children's Ministries Consent Form
UPWARD Sports Camp
July 13-16, 2010

I (We), the undersigned, parent(s), and/or guardians of _____ a minor, do hereby
(Name of minor) (Please print)
authorize Bethel Baptist Church, its adult agents and employees, unto whose care said minor has been entrusted, to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care to be rendered to said minor which is deemed advisable by and is to be rendered under the supervision of any physician and/or surgeon licensed under the provisions of the Medicine Practice Act whether such diagnosis, treatment and/or surgery is rendered at physicians office, a hospital, or anywhere else.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required but is given to provide authority and power on the part of the aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the afore mentioned physician in the exercise of his best judgment may deem advisable.

This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California.

This authorization will remain effective until **July 17, 2010**, unless sooner revoked in writing and delivered to said agents.

I (We) will not hold the church or any individual responsible in case of any accident involving the above named individual.

I (We) accept all financial responsibility for any such treatment.

(Mother's signature)

(Father's signature)

(Guardian's signature)

INFORMATION ON ABOVE NAMED INDIVIDUAL
(Please print)

NAME _____ BIRTHDATE _____

ADDRESS _____ PHONE _____

CITY _____ STATE _____ ZIP _____

FAMILY DOCTOR _____ DOCTOR'S PHONE _____

HEALTH INSURANCE COMPANY AND POLICY #

ALLERGIES TO MEDICATION: _____, _____, _____, _____

ALLERGIES TO FOODS: _____

SPECIAL MEDICAL PROBLEMS: _____, _____, _____

DO YOU TAKE MEDICATION (YES) (NO) If yes, what _____

DATE OF LAST: TETANUS IMMUNIZATION: _____ MEASLES IMMUNIZATION: _____

PERSON TO CALL IN CASE OF AN EMERGENCY - NAME _____ PHONE _____